EXPLORING EXPERIENCES OF EMOTIONALLY FOCUSED THERAPISTS SERVING INTERABLED COUPLES: AN INTERPRETATIVE PHEONOMENOLOGICAL ANALYSIS

Jose Luis Tapia-Fuselier Jr., MS, CRC, LPC, NCC

Dissertation Prepared for the Degree of

DOCTOR OF PHILOSOPHY

UNIVERSITY OF NORTH TEXAS

August 2021

APPROVED:

Dee C. Ray, Major Professor
Angie Cartwright, Committee Member
Robert Allan, Committee Member
Natalya Lindo, Committee Member and Chair of the Department of Counseling and Higher Education
Randy Bomer, Dean of the College of Education
Victor Prybutok, Dean of the Toulouse Graduate School

Tapia-Fuselier Jr., Jose Luis. *Exploring Experiences of Emotionally Focused Therapists Serving Interabled Couples: An Interpretative Pheonomenological Analysis*. Doctor of Philosophy (Counseling), August 2021, 149 pp., 9 appendices, references, 152 titles.

In the U.S., an estimated 61 million people identify as having a disability, making up 26% of all adults. The occurrence of a disability for one person within a couple impacts the physical, social, psychological, and emotional state of the person who acquired a disability, forcing changes to quality of life. Interabled couples, defined as one partner having a physical disability and the other partner identifying as nondisabled, navigate various systems of care as they respond to the needs of the partner with the disability. Emotionally focused therapy (EFT) has shown benefits in reducing relationship stress and increasing security within couples. In this study, the researcher explored the experiences of 10 EFT therapists who served at least one interabled couple in couple therapy. Participants completed a semi-structured interview designed to explore how EFT therapists make sense of their lived experiences serving interabled couples. The researcher utilized interpretative phenomenological analysis to understand how EFT therapists made meaning from their experiences serving interabled couples. Findings included four super-ordinate themes that emerged from the data including (a) ableism, (b) self-of-the-therapist, (c) relationship dynamics of interabled couples, and (d) the "fit" of EFT approach with interabled couples. The themes demonstrate a need to further explore disability-responsive practices within EFT in serving interabled couples.

ACKNOWLEDGMENTS

To my younger self, I did not realize the potential I had for so long, I have accomplished something that seemed far from reach. I must next speak about my amazing husband-Nick. Going through a doctoral journey with you has been the most rewarding experience, we have seen each other grow and step into the amazing professionals we are today. You have supported me every step of the way, you have shown me great patience and love during difficult times these past four years. I am grateful to call you my husband and go on this academic journey with you. Next, my parents-Joe and Nancy have been bright lights throughout my academic career. My parents have supported my career and path from the beginning, they have seen me struggle to find my place in school to now knowing who I am as a person and professional. They always believed in me even when I did not. To them, this is the greatest gift I could give them, to see their only child obtain the hishest degree in a field I am passionate about. Additionally, to my besties: Claudia, Amelie, Ale, Karina, Freddy, Mónica, Sarah, and Citlali, I am forever grateful for your love, kindness, and support throughout the years! To my cohort-Rainbow Fish, the friendships and connections I developed made it possible for me to reach this point. I also must thank my chair-Dee, without her guidance and support, I would be in a different place personally and professionally. She has taught me some of the most valuable lessons of being a clinician and conuselor educator that have shaped the professional I am today. I must also thank my wonderful committee-Drs. Lindo, Cartwright, and Allan, thank you for giving your time and support throughout this process, you helped make this possible! To everyone else who has been beside me throughout this doctoral journey, I thank you with all my heart! I am reminded of the village it takes to accomplish anything in life, grateful for the connections I have made and relationships that have come from this experience.

TABLE OF CONTENTS

Page

EMOTIONALLY FOCUSED THERAPISTS EXPERIENCES SERVING INTERABLED COUPLES IN COUPLE THERAPY: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS

Introduction

The Centers for Disease Control (CDC) and Prevention (2019) estimated that 61 million people reported having a disability, making up 26% of adults in the United States (US). This includes nearly one in four people under 65 years of age, and two in five adults 65 years and older. Following many years of disability activism, the Americans with Disabilities Act (ADA) was passed in 1990 which prohibited discrimination on people with disabilities (PWDs) in the US (Ali, 2013). The ADA provided opportunities and protections for PWDs, but the historical experiences of discrimination, oppression, and marginalization continue to this day (Olkin, 2017). Views of PWDs are often defined by those of the dominant group (i.e., non-disabled people; Artman & Daniels, 2010). *Disability* is defined as a person with a physical, sensory, mental, or intellectual impairment limiting their ability to fully and actively engage and participate in society on an equal basis as non-disabled people (Porat et al., 2012; United States Department of Justice, 2009). The terms PWDs and disabled person are used interchangeably in this manuscript to signify someone with a disability identity.

Acquiring a physical disability impacts all aspects of life, such as individual identity, sexual identity, employment, life plans, medical care, finances, level of functioning, family and social life, psychological health, and accessibility (Cohen & Napolitano, 2007). Those with physical disabilities account for approximately 20.5% of the US population (CDC, 2019) based on the functional types of mobility and independent living disabilities. Most disabilities acquired by individuals are not planned or expected but can occur at any stage of life regardless of gender,

race, or social class. The causes of acquiring a disability in adulthood vary based on several incidents, such as chronic illnesses, accidents, and other methods (Tellier & Calleja, 2017). Non-disabled people who do not hold a disability identity hold privileges (i.e., access) which may be impacted once a disability is acquired. The transition from non-disabled to disabled can become a difficult process depending on the severity of the disability and type of disability (Day, 2013). As mentioned, a disability can significantly impact daily functioning as well as romantic relationships (Chawla & Kafescioglu, 2012).

Interabled Couples

The occurrence of a disability for one person within a couple impacts the physical, social, psychological, and emotional state of the person who acquired a disability, forcing changes to quality of life (QOL; Day, 2013; Esmail et al., 2010). The ways in which a couple manages the heightened stress may influence their ability to adapt and cope (Gordon & Perrone, 2004). Limited literature exists in understanding the experiences of adults with acquired disabilities in romantic relationships (Hwang et al., 2007; Parker, 1993). *Interabled couples* is defined as one partner having a physical disability and the other partner identifying as nondisabled (Mattlin, 2019).

Following acquisition of a disability for one partner, interabled couples may experience relational and emotional changes within the relationship. Anxiety, depression, and grief-related symptoms may develop (Chawla & Kafescioglu, 2012; Cohen & Napolitano, 2007), as well as a shift in relationship dynamics and satisfaction (Gordon & Perrone, 2004). Adaptation to new roles and abilities results in disruptions in coping skills (Eriksen et al., 1999), high levels of stress (Tie & Poulen, 2013), and frustration for both partners (Esmail et al., 2010). The non-disabled partner may take on a caregiver role and responsibilities which depends on the disabled

partner's disabilities and severity (Gordon & Perrone, 2004; Kreuter, 2000). Relational shifts creating an imbalance of power may potentially place the relationship at risk (Kreuter, 2000). The couple's systems of support, such as home care, friends, family, religion and spirituality, and support groups may change rapidly and be at risk (Cohen & Napolitano, 2007). These systems are vital to the overall health of the couple because many aspects of the relationship may change to necessitate assistance from outside support. Limited information exists on the number of relationship counselors (i.e., couples and marriage counseling and other professionals) trained to work with interabled couples as well as their lived experiences of providing disability affirming therapy (Hunt et al., 2009; Olkin, 2017).

Emotionally Focused Therapy

Emotionally focused therapy (EFT) is an empirically validated approach to couple therapy (Dalgleish et al., 2015; Johnson & Greenman, 2006) with over 30 years of research. Johnson (2019) suggested that EFT offers a map and guide to understanding relational processes and clear therapeutic goals for couples, individual, and family therapy. EFT therapists work to provide three key factors for security in attachment bonds: accessibility, responsiveness, and emotional engagement (A.R.E.; Johnson, 2019). EFT concentrates on empathic understanding of couple's immediate experience with interest in emotions and frame of references (Johnson, 2019). Within the EFT model, the roadmap to healing and change follows three stages: (1) the de-escalation of negative cycles of interaction-relationship stabilization, (2) changing interactional positions, and (3) consolidation and integration (Johnson, 2019).

Among the various couple therapy approaches, a meta-analysis of 9 randomized controlled trials (RCTs) found EFT demonstrated a 70-73% improvement rate for relationship distress in couple therapy (Johnson et al., 1999). Wiebe et al. (2016) highlighted the long-term

effectiveness of EFT couples therapy in their report that 46.4% of couples in their sample maintained relationship satisfaction at 24 months post therapy. Research continues to be conducted to examine the application of EFT with diverse populations such as couples dealing with infertility (Najafi et al., 2015), women dealing with breast cancer (Naaman, 2009), and end-stage cancer (McLean et al., 2013). The increase in research in EFT has also expanded to explore the experiences of therapists completing EFT trainings and supervision. The rationale of exploring therapists' experiences is due to limited information known about the overall training outcomes for therapists both quantitatively and qualitatively (Bell et al., 2018).

Disability Education for Mental Health Professionals

During the clinical development of graduate level students in mental health (e.g., mental health counselors, clinical social workers, clinical/counseling psychologists, marriage and family therapists), a range of content is provided to ensure competent and responsible professionals emerge into the field post-graduation based on standards set by various accredited bodies for student preparation. In clinical training, limited coursework is provided to graduate level students to work with clients with disabilities in non-rehabilitation programs (Artman & Daniels, 2010; Olkin, 2017). In examination of four accrediting bodies for clinical training, including the Council for Accreditation of Counseling and Related Educational Programs (CACREP), American Psychological Association Commission on Accreditation (APA-CoA), Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE), and Council on Social Work Education (CSWE) Commission on Accreditation, there appeared to be a lack of attention to disability-focused curriculum within non-rehabilitation programs.

Post-graduate licensing requirements vary across state-based licensing boards. For example, the US has approximately 48,000 licensed marriage and family therapists (LMFTs; US

Bureau of Labor Statistics, 2018), 140,000 mental health counselors (US Bureau of Labor Statistics, 2016) who may hold licensure as a professional counselor (LPC), 160,000 clinical psychologists (PsyD; US Bureau of Labor Statistics, 2018), and 124,000 licensed clinical social workers (LCSW; US Bureau of Labor Statistics, 2016). With a license, many professionals serve a variety of clients with specific needs in different modalities (i.e., individual, couple, family, and play therapy) and theoretical approaches. The limited training available during graduate coursework in disability studies across the four accreditation bodies warrants examining current licensed professionals (i.e., LPC, LMFT, PsyD, PhD, LCSW) and their lived experiences working with clients with disabilities.

Purpose of the Study

Within counseling literature, limited studies have examined the lived experiences of therapists serving clients with disabilities (Rivas & Hill, 2018). Even within the extant literature on multicultural counseling, there is a limited focus on people with disabilities (Artman & Daniels, 2010). Currently, the research literature lacks an in-depth qualitative investigation of licensed professionals providing services to interabled couples in relationship counseling (Gordon & Perrone, 2004). Within relationship counseling, many theoretical approaches exist to address couple distress, but few examine the experiences of clients with disabilities (Allan & Ungar, 2012; Tellier & Celleja, 2017). One theoretical approach to working with couples, EFT has demonstrated strengths in serving relationships where one partner has a disability/chronic illness by reducing stress and improving coping strategies when one partner has a chronic illness (Chawla & Kafescioglu, 2012; Stiell et al., 2007). Although much quantitative research has been done serving various types of relationship issues in EFT, little is known about the lived experiences of EFT therapists in providing services to interabled couples as well as the type of

disability training they have received to competently serve these couples.

The purpose of the current study is to examine EFT therapists' lived experiences in serving interabled couples after one partner acquires a disability. Given the limited training provided to licensed professionals on disability-responsive and disability affirming care, examining the meaning making of therapists in serving disabled clients in romantic relationships provides an opportunity within EFT to enhance therapy outcomes, service delivery, and reduce barriers to interabled couples. The guiding research question is: How do EFT Therapists make sense of their lived experience working with interabled couples in couple therapy?

Methods

Interpretative phenomenological analysis (IPA) is a qualitative research method centered in exploring the meaning people give to their lived experience or process (i.e., lifeworld; Smith, 2011; Smith et al., 2009). The choice of IPA as methodology for this study was based on the idiographic approach to centering the participants' meaning making experiences of providing therapy to interabled couples. IPA draws on three key areas of philosophy of knowledge: Phenomenology, hermeneutics, and idiography which combined provide a focus on a particular to the shared and from the descriptive to interpretative analyses (Allan & Eatough, 2016; Smith, 2011; Smith et al., 2009). Larkin et al. (2006) highlighted that IPA is committed to two processes including giving voice to participants (phenomenological) and contextualizing those voices from a psychological perspective (interpretative).

Participants

The use of purposive sampling, as recommended in IPA, was used to capture the meaningful experiences of a homogenous group's experience with a specific phenomenon (Smith et al., 2009). Participants met the following inclusion criteria: (a) a non-rehabilitation

counseling master or doctoral level therapist with a degree in mental health counseling or related degree, (b) licensed to practice, such as: licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), licensed clinical social worker (LCSW), licensed psychologist (PsyD/PhD), or other related license, (c) currently provide or have provided services to at least one interabled couple, (d) have completed advanced training in EFT (i.e., externship and core skills) or certified by the International Center for Excellence in Emotionally Focused Therapy as an EFT therapist, supervisor, or trainer.

Consistent with Smith et al.'s (2009) recommendations for large studies, the current study included 10 participants. Of the 10 participants, two identified as men and eight women. Nine participants identified as white and one who requested to not have their race/ethnicity identified in the study. Eight participants identified only serving one interabled couple while two having served more than five. The range of ages of participants was 28 to 63 with a mean age of 46.3 and *SD* = 11 years. Participants ranged in their experience providing EFT, the range was from 2 years to 10+ years of providing EFT in couple therapy with a mean of 6.1 years (*SD* = 2.6). The majority of participants identified only serving one interabled couple while two having served more than five, with a mean of 2.9 (*SD* = 2.7) couples seen. All participants were certified EFT therapists and six were also certified EFT supervisors. Four participants were licensed as LMFT, three as LCSW, one as LPC, one as psychologist, and one participant held double licenses as LMFT and LCSW.

Procedures

Upon institutional review board human subjects approval, the research team (i.e., principal researcher and auditor) met to discuss the purpose of the study and research question. As the researcher, I engaged in personal and epistemological reflection throughout the study

(Smith, 2011). The research team met to review the procedures for auditing process and discussed any questions during that time. Once reflections and initial meeting were completed, the interview schedule was piloted with a volunteer counselor to receive feedback in order to redraft questions (Smith et al., 2009). Once the interview schedule was finalized, I began to recruit participants.

The participants were recruited using a typed script describing the study through email. The script outlined the research study, purpose, eligibility criteria to participate in the study and length of time involved. A list of potential participants were identified using the ICEEFT website through the directory in the U.S. which resulted in over 2,000 names. The script was sent to the first 400 ICEEFT members throughout the U.S. Once a potential participant responded, a review of eligibility criteria was conducted for trustworthiness of sample (i.e., homogenous). A secure link was sent with the consent to participate along with a demographic questionnaire. I completed each interview using the interview schedule that ranged between 35-70 minutes. Following the interview, I obtained a transcript of each interview using REV.com. Smith and colleagues recommend verbatim transcription be completed immediately following the interview. As transcripts were obtained, member checking was compelted with each participant to review for accuracy and provide any feedback (Stake, 1995). After member checking was completed, the data analysis process began.

Data Sources

Given the nature of IPA in exploring meaning making, one-time in-depth semi-structured interviews were utilized for data collection (Larkin & Thompson, 2012; Roebuck & Reid, 2019; Smith et al., 2009). An interview schedule was utilized with questions derived from the research question and topic of interest. The interview schedule was designed to be flexible and non-

leading. Smith et al. (2009) recommended the interview schedule be between 6-10 questions with prompts. Prompts were used with each question to explore the participants' experiences in more depth. The interview schedule consisted of eight questions with prompts. Each interview lasted between 35-70 minutes.

Data Analysis

Interviews were transcribed verbatim, below are the steps utilized throughout the analysis process as recommended by (Smith et al., 2009): First step involved reviewing transcripts and completing member checks to review for accuracy before engaging in the data analysis process. Transcripts were read and re-read and notes were taken based on information that stood out during the re-reading process. Second, three types of comments were deployed as suggested by Smith (2011; i.e., descriptive, linguistic, and conceptual) to engage with the text. Third, emergent themes were explored through interrelationships, connections, and patterns between the three types of comments. The process shifted from the entire transcript to the comments (i.e., hermeneutic circle). Once emergent themes were identified, individual charts/map of the themes were created to group similiaries and connections using the technique subsumption to develop super-ordinate themes. An auditor was utilized throughout the data analysis process at three stages (i.e., 10%, 50%, and 100% of data analyzed) as well as peer debriefing and quality checks. Lastly, once all participant cases had completed chart/maps, connection, patterns, and differences were examined which resulted in reconfiguration and relabeling of themes.

Positionality

The research team included myself as lead researcher and an auditor. I have 10 years of experience working with the disability community in professional and clinical positions in case management, state rehabilitation, private rehabilitation, and private practice. Additionally, I held

assumptions that interabled couples require specialized support in couple counseling. I am aware of held biases about sexuality and disability which were explored through reflexivity to prevent misinterpretation of data. My positionality has potential to impact overall findings and interpretations as I do not identify as being in an interabled relationship and have no personal experiences with having a disability. I identify with multiple marginalized groups/identities and is in a same-gender marriage. My collective experiences have created a desire to further examine the support available for interabled couples in couple counseling using EFT.

The second member in the research team served as an auditor who holds a PhD in counseling and holds various marginalized identities. The auditor also has experience in qualitative research in participatory action research and photovoice. The use of an auditor provided support in examining and evaluating internalized biases and held beliefs about people with disabilities and EFT throughout the research process. The use of an auditor assisted in deepening the analysis process in IPA as well as enhance trustworthiness.

Trustworthiness

To increase credibility and trustworthiness in an IPA study, I utilized several validation strategies and techniques such as audit trail, peer debriefing, member checks (Birt et al., 2016), reflexivity (i.e., personal and epistemological; Smith et al., 2009), quality checks (Dickson et al., 2011), and the use of IPA quality evaluation guide (Smith, 2011) to increase trustworthiness. To ensure quality and rigor for trustworthiness, Smith (2011) developed the IPA quality evaluation guide to establish standards for good, acceptable, and unacceptable research. Smith qualifies good IPA research as meeting the following criteria: (1) subscribes to theoretical principles of IPA, (2) sufficiently transparent, (3) coherent, plausible, and interesting analysis, (4) sufficient sampling to show density of evidence for each theme (i.e., extracts from three participants for

each theme and measure of prevalence or extracts from half of sample for each theme when over eight participants), (5) well-focused, (6) data and interpretation are strong, and (7) reader is engaged.

Results

The research study was guided by the research question and the interview schedule. The data analysis process led to the emergence of four super-ordinate themes: (a) ableism, (b) self-of-the-therapist, (c) relationship dynamics of interabled couples, and (d) the "fit" of EFT approach with interabled couples.

Super-Ordinate Theme 1: Ableism

Throughout the interview process, participants shared their various experiences of serving interabled couples in couple therapy. For many of the participants, their perceptions of people with disabilities were described with deficit-oriented language. Ableism includes negative, deficit-oriented views of disability shaped by the history of treatment towards people with disabilities, societal messages of "otherness," and cultural understandings which informs one's own understanding of disability (Nario-Redmond, 2020). Many participants described their experiences through deficit-oriented language around their clients with disabilities. This language included seeing disability as "permanently damaged," "physically challenged," "struggle," "a darkness," and "affliction." Seven participants utilized deficit language in describing their lived experiences serving interabled couples. Different participants expressed various overt and covert messages of ableism.

Rose's comments around disability demonstrated the use of deficit-oriented language. That is, even in discussing the word "disability," Rose became visually uncomfortable and stated "I really, really hate the word disabled. I always do my best not to use it. I prefer to use relative

able ability instead of disability because disability is a very belittling word." For Rose, the word "disability" itself was, in essence, deficit-language.

Alternatively, a few participants shared their experiences while being cognizant of ableism and naming disability as a social construct during the interview. For example, Love Worker described a disabled client using both deficit-oriented language and disability-responsive language by stating:

> Again, sort of mindful of what might be happening for them. Curious, do they have any kind of anxiety or embarrassment?...Just wanting to sort of give them space in some kind of respect and dignity that I would hope to give anybody that comes into my room.

Super-Ordinate Theme 2: Self-of-The-Therapist

Also prevalent in the data was the theme of self-of-the-therapist. This included awareness of one's inner process, knowing oneself, and unexplored parts of self that impact client and therapist. The self-of-the-therapist super-ordinate theme was identified in all 10 participants, each highlighting various aspects of self and their work with interabled couples. The four nested themes discussed are (a) therapist insecurities, (b) impact on therapist's behavior; (c) emotional impact on therapist, and (d) heightened self-awareness.

Therapist Insecurities

This theme encompasses the ways therapists' insecurities show up in clinical work and the various methods therapists deployed to navigate the discomfort. All ten participants emphasized their own insecurities in serving interabled couples. For many participants, these insecurities often resulted in an increase in self-awareness. For example, Caroline shared her experience in her initial contact with an interabled couple and the fear and anxiety that she experienced by stating:

Part of the fear is like, can I find a way into their space? Can I see what's happening? Can

> I come alongside them in a way that feels meaningful? Can I build the alliance that helps them feel safe, so they can take the risks, so they can do this work? And then if they have anything else extra in terms of layers like disabilities, will I be able to understand enough of what they're experiencing so that I can accommodate in a way that feels honoring to them, meets their needs?

Caroline expressed great concern in wanting to serve them properly and worried about her own capabilities to serve interabled couples. This experience was common across participants in describing the initial fears with serving interabled couples.

Impact on Therapist's Behavior

Impact on therapist's behavior encompasses experiences of therapists serving interabled couples and the therapists' mental barriers that showed up in their work. As part of self-of-the-therapist, understanding one's own internal process helped ensure the therapeutic process was not greatly impacted by negative views of clients' identities. For example, Sasha shared her experience in navigating how she explores the client's disability within couple therapy. She stated:

> So maybe a word to say would be tentative around just really wanting to get it right and wanting to not be like, "Oh, I don't see your disability." [moving hand over face] Right? But also not be invasive or overly focused on, "All I can see is that you don't have the rest of your arm and that we should talk about that again. Let's talk about that again."

Sasha shared the difficulty of discussing the disability while also not overly focusing on it during therapy. She explains the desire to get it "right" and not evade the topic of disability but not having it take too much space in session.

Emotional Impact on Therapist

In addition to the therapist's behavior being impacted serving interabled couples, participants described the long-term impact on them as therapists. The impact each therapist experienced serving interabled couples varied, seemingly based on their own knowledge of

disability. For example, Cristina openly shared the difficulty in life being unfair to interabled couples. She stated:

> I think… this is really hard. It's really not fair and it's hard, and a little bit of like, there's nothing to be done with that. I don't know. There's so many ways in our world, in this country in particular, which we'd want to fix or do. We think we can overcome anything and everything, and we always have a plan for something. And like you can't [smiles]. And that's just painful and hard.

Cristina reflected on her experience and felt the weight of aspects of the interabled couple's life not changing, specifically the disability. She mentioned the pain and difficulty of not being able to change the disability for the interabled couple.

Heightened Self-Awareness

As participants shared their insecurities and the emotional impact serving interabled couples, the discussion evolved to many expressing a heightened awareness of self. This self-awareness involved understanding themselves more and identifying ways to support interabled couples. For one participant, serving interabled couples expanded their understanding of emotion. Caroline stated:

> I don't know, it just expands my understanding of the possibilities of pain in this world, the range, the variety, the flavor, the color, how it can impact somebody… How much is the physical stuff underneath it? But what meaning lands on the other partner. And had them processing that meaning so that they can get clear signals.

Caroline described the expansiveness in emotion, specifically pain. She described pain with various layers of complexity.

Super-Ordinate Theme 3: Relationship Dynamics of Interabled Couples

This super-ordinate theme of relationship dynamics of interabled couples includes the meaning made by the therapists' work with each partner in the interabled couple, dynamics of interabled couples in couple therapy, and therapists' conceptualization of interabled couples'

relationship. The four nested themes identified are (a) disabled client's experience, (b) non-disabled partner experience, (c) interabled relationship dynamics, and (d) therapists' conceptualization of interabled couples.

Disabled Client's Experience

Many participants shared different experiences working with each partner within an interabled couple. They all highlighted the differences that exist between the disabled partner and non-disabled partner and spent time sharing the meaning they made of the client with a disability. For the client with a disability, many participants shared the internal pieces of self that emerged in therapy. For example, Mimi discusses the view-of-self piece for clients with disabilities that were necessary to explore in couple therapy. She stated, "We're talking about these really vulnerable view-of-self kinds of things when we do EFT… a lot of times, negative view-of-self that's connected to that disability." Mimi expressed a big part of EFT is looking at view-of-self pieces in therapy which for the partner with the disability was connected to the disability.

Non-Disabled Partner's Experience

Many participants shared experiences of non-disabled partners in couple therapy and the various roles they may carry within their interabled relationship. Dolly mentioned the role the non-disabled partner played during therapy, often stepping in to assist Dolly with statements made by the partner with a disability. She explained: "Depending on the dynamics that were different with each couple, but the partner that did not have the disability was used to being a translator, or just the one that was like the helping partner." Dolly expressed the difficulty in balancing the role of the non-disabled partner in session to ensure the therapeutic process was not greatly impacted.

Interabled Relationship Dynamics

Within the interabled relationship dynamics theme, participants shared their perceptions of unique differences serving interabled couples compared to non-disabled couples. Differences in relationship dynamics for interabled couples were noted in all participants. Specifically, the differences in equality between interabled couples and the various shifts to coupledom.

Sophia emphasized the differences in experience for interabled couples when she stated: "Financial burdens, emotional burdens, physical burdens. Overall, it's very complicated. There's extreme grief and loss." The compilations for some interabled couples in balancing their financial and relationship changes experience extreme grief and loss.

Therapists' Conceptualization of Interabled Couples

Many participants worked to conceptualize interabled couples' experiences and shared their understanding within EFT. For example, Cristina shared factors she considered in conceptualizing the interabled couple. She stated:

> And they were coming to me a couple of years after that period when things were starting to get harder. Some of it was just unprocessed trauma that they experienced together…Yeah. Just kind of in those pieces that I'm saying in terms of ... I mean, [long pause] I think you might need to really understand the impact of the role changes for couples when a disability happens in the context of their relationship. So, like there are kind of acute things that I think still fit with EFT, but just it might be like additional things to be aware of as you put it into the EFT process and cycle.

Cristina expressed the importance of considering the disability as part of the relationship and applying to the EFT process. Another participant emphasized the importance of considering disability as an important factor in couple therapy.

Super-Ordinate Theme 4: The "Fit" of EFT Approach with Interabled Couples

Finally, many participants discussed the strengths and limitations of EFT and its application to serving interabled couples. All participants provided guidance and

recommendations for ways EFT can support their work in serving interabled couples. The final super-ordinate theme presented contains four nested themes: (a) Strengths of EFT; (b) Limitations of EFT; (c) Disability-Responsive Adaptations; and (d) Future Recommendations.

Strengths of EFT

Participants shared their experiences engaged with the EFT approach and its impact on clients they have served over the years. For Sophia, EFT fits all couple situations that present themselves in couple therapy. She stated:

> I think EFT is really the perfect fit for any type of situation, because couple work is about connection, helping people reconnect, and helping them recognize negative patterns that are causing them to disconnect. I love EFT, because you make the enemy the negative cycle…Just helping people get that new perspective, EFT fits with, I think, any type of couple situation. [laughs]

Limitations of EFT

While EFT has many strengths in serving couples in couple therapy, most participants identified limitations in serving interabled couples. These limitations varied based on the type of disability and interabled couple's needs. Participants shared their challenges in providing standard EFT.

For example, Kate shared the difficulties in making modifications. She stated: "I think the most challenging part for me was just modifying EFT in a way that didn't feel dismissive or invalidating of her [partner with disability]." She expressed the difficulty in not being dismissive in modifications that considered the partner with the disability's needs. Similarly, Dolly expressed being limited in serving the client with a disability using standard EFT. She stated:

> Yeah, I felt very limited, felt like, I think something that was hard is I felt like, am I actually helping them. Again, didn't necessarily feel like I could do the same kind of EFT that I was used to doing that I had confidence in.

Dolly shared feeling limited in applying the same EFT with her interabled couple. She also expressed not feeling as confident in herself.

Disability-Responsive Adaptations

Considering the participants' observed limitations of EFT, nine participants described disability-responsive adaptations they made when working with interabled couples. The majority of participants shared various methods they attempted to adapt their standard EFT process to meet the needs of clients with disabilities.

In examining the work therapists do upon scheduling a client, Cristina shared her experience of answering the interabled couples' initial questions. She stated:

> I had some hesitance honestly, in kind of figuring out, is that going to work? And so, I kind of explained what my office is like and what I would be able to do. I did need to make some adjustments, but small adjustments in terms of chairs and things… I took the measurements of my office. They said that would work. We said, "Let's give it a try. Let's see how it goes."

Another participant shared the importance of having additional information about the disability at the start of couple therapy. Kate shared: "Then the partner with the traumatic brain injury brought in his medical history for me when I first met him, so I could get a better sense of where he was coming from, which was helpful."

Future Recommendations

Future recommendations were highlighted by many participants in identifying their needs to better serve interabled couples. The most common recommendation shared was a training on interabled couples. For example, Love Worker stated: "I think there needs to be a training on doing EFT with interabled couples. I think that would be a fabulous masterclass." In addition to a training being offered, Mimi mentioned the utility of having video examples.

Discussion

The purpose of this study was to examine the lived experiences of EFT Therapists serving interabled couples in couple therapy. I further sought to understand the ways therapists modified or adapted their work for interabled couples. By answering the established research question, this study affirmed, built upon, and added to the extant literature on EFT and serving clients with disabilities, more specifically, interabled couples. The study resulted in four super-ordinate themes (a) ableism, (b) self-of-the-therapist, (c) relationship dynamics of interabled couples, and (d) the "fit" of EFT approach with interabled couples. The lived experiences of EFT therapists serving interabled couples varied in the ways they approached the topic of disability, modified interventions, and navigated their own emotional experiences. The study further highlighted and built upon the importance of understanding therapists' experiences due to the limited information available (Bell et al., 2018).

Ableist Views

A common experience identified by most of the participants was viewing the client with a disability through a deficit-oriented lens. Aligned with the IPA requirement to contextualize the voice of participants from a psychological perspective to fulfill the interpretative commitment of IPA (Larkin et al., 2006), the use of the ableism framework (Nario-Redmond, 2020) emerged during the data analysis process and was informed by literature and participant narratives. The ableism framework (Nario-Redmond, 2020) includes deficit-oriented views and beliefs about PWDs. Deficit language became apparent through the analysis process as themes were being explored. Many participants described partners with a disability as "permanently damaged," "afflicted," and a "struggle." Ableism like other forms of discrimination have long standing histories in the U.S. and have informed the ways others view PWDs. In understanding the use of

certain terms to describe PWDs, it is imperative to examine the history of ableism in the U.S.

As mentioned, models of disability have existed for many centuries which have shifted the ways PWDs are viewed and treated. Historically, PWDs were denied personhood, dehumanized, and seen as a negative result due to an act of god (Retief & Letšosa, 2018). For example, in the U.S., women with disabilities experienced forced sterilization during the 19th and 20th century, while other PWDs were forcefully institutionalized for having a disability (Morris, 1991). While PWDs make up the largest minoritized group in the U.S. (Brault, 2012), discrimination, oppression, and marginalization continue to play a role in the lived experiences of PWDs. Given the long history of negative views of PWDs, Park et al. (2003) concluded many individuals in their qualitative study reported their fear and disgust of catching an illness which resulted in avoiding PWDs based on their visible appearance. These examples of discrimination, prejudice, and oppression contribute to current views of PWDs. For example, ableism exists in many facets of life, such as employment. In the U.S., 76.8% of non-disabled people were employed compared to 35.9% of PWDs (Lauer & Houtenville, 2018), with living wages being less than non-disabled workers. PWDs have experienced a long history of inequity in regard to employment long before the Americans with Disabilities Act (ADA) of 1990 was passed. PWDs continue to experience barriers in obtaining gainful employment based on discrimination and marginalization (Nario-Redmond, 2020; Olkin, 2017).

Given the historical context of disability in society, activism within the disability community has continued to reclaim the word “disability” not as a deficit but a strength and part of self-identity (Olkin, 2017). The increased representation in of PWDs in media created opportunities to examine peoples’ understanding of PWDs in society (i.e., in relationship, successful jobs, healthy relationships, and lives). The result of increased representation and

disability activism may have confused both non-disabled and some disabled individuals regarding proper use of the term "disability" and other terms such as, "wheelchair bound," "autistic," and "disabled." In understanding the history of ableism in the U.S., views of deficit language vary among certain disability groups (i.e., people born with disability and people who acquire disabilities; Nario-Redmond, 2020). Within the last decade, the push for social and racial justice in society and various professions (e.g., field of mental health) requires an examination of the language used as well as an important factor in the therapeutic process.

As many participants in the current study utilized deficit-oriented language it is not surprising considering the forces of ableism and ableist ideologies that exist in society. The majority of participants were not aware of ableism as a force contributing to their narrative and shared their experiences without direct awareness of the use of deficit-oriented language. Moreover, these forces and ideologies exist and, in this case, may be perpetuated in counseling practices for these participants. For example, one participant, Rose, reported that the word "disability" itself was, in essence, deficit-language. While Rose's statement itself communicated ableist ideals, there are communities of disabled people as mentioned who use this very language to describe their identities and their experiences which is not inherently deficit-oriented but rather empowerment and part of their self-identity. Rose's personal view of the word "disability" has the potential to contribute to her professional conceptualization of a client with a disability, specifically interabled couples. The use of deficit-oriented language in describing people further perpetuates ableist ideals and reduces equitable access and inclusiveness. As mentioned, seven participants used deficit language, this study affirmed the presence of covert ableism in counseling conceptualization that may influence the therapist's ability to serve clients from a disability-responsive lens rather than from a deficit lens. Furthermore, the acknowledgment and

examination of ableism as a force in therapy may yield additional recommendations for training and supervision around disability-responsive practices.

Medical Model as Contributor to Ableism

The medical model of disability has provided context and information throughout history to describe the perceptions of PWDs. Participants in the current study seemed to be heavily influenced by the medical model in conceptualizing their clients. For example, one participant, Sophia, described her client as being "permanently damaged" where "doctors couldn't repair" the partner. When Sophia described the situation the interabled couple experienced, the language used was derived from the medical model which views PWDs as "needing to be fixed or cured" to be accepted. All participants described the caution they felt when serving interabled couples, as many mentioned the desire to "get it right" when discussing disability.

The experiences of some participants highlight the influence of ableism in professional practice and the impact of limited knowledge in serving clients with disabilities. The responses from a few participants were mindful of ableism and were cautious to not contribute to ableist practices and language. Other participants shared their experiences of serving interabled couples from a deficit-oriented lens. Their perceptions and views of disability may directly impact their conceptualization of the presenting issues and overall treatment (Rivas & Hill, 2017). In qualitative analysis, Rivas and Hill (2017) noted the theme of medicalization regarding the therapist's ability to conceptualize clients with disabilities. In the Rivas and Hill (2017) study, participants described seeing the disabled clients' issues through a medicalized narrative which often came from information based on psychopathology (i.e., DSM). Additionally, they reported that within conceptualization was the issue of not identifying the stigma, discrimination, marginalization, and oppression often experienced by PWDs.

The therapist's conceptualization of the interabled relationship and presenting issues directly impacts decision-making in session, such as what is explored, what information is asked, interventions, and overall treatment. The negative impact to the therapist's conceptualization varies based on their level of self-work and understanding of disability from a strength-based perspective. This study adds to the literature, specifically following the Rivas and Hill (2017) findings that counselors-in-training with limited training in disability often conceptualized disability from a medicalized narrative. Utilizing a medicalized or deficit-oriented lens to conceptualize interabled couples may create opportunities to unknowingly cause harm to the therapeutic process and perpetuate ableist ideals (Leigh et al., 2004; Rivas & Hill, 2017).

Impact of Ableism on Therapeutic Process

Participants in this study shared increased caution in serving interabled couples. Many reported the fear of saying something incorrectly and hurting the disabled partner's feelings. The participants' fears appeared to be rooted in empathy and compassion in not wanting to disrupt the therapeutic relationship. There was a concern from participants in focusing on the disability too much during therapy. Many participants shared working to find a balance of when to discuss the partner's disability and when to allow the partner space to speak about their disability. These experiences shared by many participants emphasize the importance of examining beliefs about disabilities held by therapists serving interabled couples. As discussed, ableism is a powerful force in society that has universal impact. Given the deficit-oriented language of many participants, examining therapists' beliefs and understanding of disability provides an opportunity to prevent potential harm, disruptions, and ruptures in the therapeutic relationship. Additionally, exploring therapists' beliefs and understandings of disability allow for ableist views to be unlearned and an opportunity to relearn disability-responsive practices.

Training in Serving Interabled Couples

The majority of participants shared the importance of a need for training in serving interabled couples. In surveying psychologists' perceptions of serving clients with disabilities, Leigh et al (2004) found that a large gap in provider knowledge led to increased barriers in the therapeutic process. In the current study, one participant, Cristina, mentioned the importance of training in serving interabled couples to reduce barriers of interabled couples needing services but was unable to locate or identify a provider with experience or knowledge of interabled couples. Given the vast experiences of individuals who acquire disabilities and their relationship with the disability, exploring disability-responsive practices within couple therapy is warranted.

In addition to lack of training on serving interabled couples in EFT, participants seemed to lack self-awareness on personal levels of ableism. In their review of the literature, Tellier and Calleja (2017) noted a need for therapists to examine held beliefs about PWDs in order to mediate their assumptions and biases regarding disability. Alternatively, not addressing internalized assumptions and beliefs about PWDs can lead to harm caused to the therapeutic relationship which goes against various professional code of ethics (ACA, 2014; AAMFT, 2015; APA, 2017; NASW, 2017). As described, training programs often do not focus on disability-responsive practices serving PWDs which creates opportunities to offer therapists a self-of-the-therapist training centered on ableism to explore held beliefs (Olkin, 2017). A few participants shared the importance of such a training for therapists to help improve service delivery working with interabled couples.

EFT Fit as a Viable Approach to Serving Interabled Couples

As reported by all participants, EFT was viewed as a good fit for serving interabled couples. Studies have demonstrated the effectiveness of EFT after an onset of a disability or

chronic illness (Chawla & Kafescioglu, 2012; Fitzgerald & Thomas, 2012; Naaman, 2009; Wiebe & Johnson, 2016) which further suggests the potential fit of serving interabled couples. Participants mentioned the power of a strength-based attachment focused approach in serving clients. Many reported the innate attachment needs of all humans situates EFT as an important approach to serving interabled couples. Parra-Cardona et al (2009) emphasized this point and stated many core components of EFT can be adapted to serve clients with disabilities.

Many participants reported adapting the EFT model to best fit their interabled couples. Each participant modified their approach based on the needs of the partner with a disability. Many reported the flexibility of EFT, such as Jack, who shared his process working with his interabled couples often required the process to go slower. Others had similar reports of slowing the process down in moving through the stages and steps of EFT. Dolly mentioned incorporating more behavioral components to her work due to concerns over the limitations of the partner with a disability.

Barriers in EFT trainings have been captured in previous studies that identified limited training examples focused on heteronormative non-disabled couples (Wiebe et al., 2016). Reports from participants indicated limited diverse examples during their EFT trainings and the impact it had on them working with diverse couples. Many mentioned relying on their EFT supervisor for support and others mentioned using empirical research to assist in serving diverse couples. Recently, ICEEFT approved trainers have incorporated more racially diverse and affirmative trainings in the wake of George Floyd's murder and Black Lives Matter movement, but little have focused on clients with disabilities or interabled couples.

Many participants advocated for a training to be provided to EFT therapists serving interabled couples. Within ICEEFT approved trainings in EFT, a few studies have examined

therapists' experiences learning EFT. Bell et al (2018) reported many therapists feeling stuck and needing more examples during training. Consistent with Bell et al.'s (2018) recommendation to include examples of interabled couples to increase and improve quality of inclusiveness during the training experience, findings from the current study support this recommendation.

EFT Supervision as an Avenue to Support Therapists and Interabled Couples

An additional aspect that suggested EFT as a viable approach to serving interabled couples is therapists' engagement in EFT supervision. All participants mentioned continuing their own supervision after meeting all their requirements for licensure and certification. All participants mentioned engaging in ongoing EFT supervision and consultation which allowed for additional layers of support. Participants shared the use of supervision as a benefit to improving the quality of care and services provides to all couples. While ICEEFT requires only eight hours of supervision to be certified, all participants were certified and continued supervision and consultation. However, participants reported that their EFT supervisors had no experience serving interabled couples. While the process to become a supervisor may be extensive, limited information is known about the training in serving clients with disabilities. Considering the influences of ableism within the therapeutic space, supervisors may be unaware of the potential barriers from the EFT therapists during supervision.

Limitations

While the study produced various findings, there are several limitations that exist. The sample size of the study (n=10) poses limitations to transferability. Additionally, the EFT therapists involved in the study shared experiences of serving interabled couples with an acquired physical disability which did not include partners with congenital disabilities. Future studies might explore this by including all types of disabilities in interabled couples. The current

study focused on lived experiences of EFT therapists serving interabled couples', yet the interabled couples receiving couple therapy were not included in this particular study. The lack of interviews with interabled couples limits the perspective to therapists. Additionally, due to the nature of this qualitative study, there are no conclusions about effectiveness of EFT with interabled couples. The findings support better understanding of how EFT therapists work with interabled couples but methodology precludes any exploration of efficacy or outcomes of EFT with this population.

Implications for Clinical Practice

This study generated five implications for clinical practice. First, the findings suggest the importance of therapists examining themselves and their held beliefs and assumptions about PWDs. The self-of-the-therapist requires exploration of ableist ideals and unlearning and relearning beliefs about PWDs. This exploration leads to an increase in self-awareness and increased confidence to address identity differences within the therapeutic relationship. Given the various accrediting bodies for clinical training across professions, many emphasize the importance of exploring and examining the "self" as a mental health professional and ways therapists own history can influence the therapeutic process (APA, 2019; CACREP, 2020; COAMFTE, 2020; CSWE, 2020).

Second, in exploring self-of-the-therapist work, examining training programs is an important aspect of addressing these issues from the start of clinical training. Increasing disability-responsive and disability-affirmative content within courses provides trainees opportunities to work through their own barriers before serving clients with disabilities and is congruent with ethical codes set by various professional organizations (ACA, 2014; AAMFT, 2015; APA, 2017; NASW, 2017). Educators are encouraged to consider integrating disability-

related content throughout the curriculum. As mentioned, 61 million Americans identify as having a disability (CDC, 2019), therapists are likely to serve clients with disabilities. Increasing discussions, case and clinical examples, and content about PWDs from a strength-based lens may reduce ableist ideals and ideologies from being perpetuated in the therapeutic relationship.

Three additional implications for clinical practice are connected to EFT as an approach. First, recommendations for EFT model to be more inclusive of diverse couples, specifically, interabled couples provides therapists more resources to best support their clients. The EFT model can include a roadmap for serving interabled couples throughout the stages and steps. Second, training is needed in EFT to serve interabled couples. The training includes clinical examples and opportunities to explore understandings and perceptions of PWDs and explore disability-responsive practices and disability affirmative language that reduces medicalized narratives therapists may use in conceptualizing interabled couples. Lastly, offering opportunities for EFT supervisors to engage in self-of-the-therapist training around interabled couples also provides support in supervising EFT therapists serving interabled couples (Aponte & Kissil, 2016; Sandberg & Knestel, 2011). Creating opportunities for both EFT therapists and EFT supervisors to engage in unlearning ableist ideals and relearning disability-responsive practices further promote the service delivery for interabled couples.

Based on the findings of this study, it is recommended that therapists work toward establishing disability-responsive practices. Part of disability-responsive practices is having the therapist work with interabled couples to help process personal assumptions and biases held about PWDs. Artman and Daniels's (2010) suggested working to prevent further relationship harm by both partners processing their adjusting to the disability. Hunt et al (2009) and Martire

(2013) both recommended the importance of assessing the interabled couples' ability to advocate for their needs.

Implications for Research

This study generated four implications for research. First, participants identified the importance of hearing from interabled couples and identifying their needs. Little is known about interabled couples' experiences in couple therapy. Examining interabled couples' experiences in EFT couple therapy can yield valuable information about modifications and adjustments made within EFT to improve therapeutic outcomes. Another recommendation is examining interabled couples' experiences of ableistic (i.e., oppressive and deficit-oriented) messages in couple therapy, specifically, its impact on the therapeutic relationship and outcome. Another implication for research is EFT therapists' perceptions of ableism within the therapeutic relationship, specifically, therapists own awareness and knowledge of ableism and its potential impact on the therapeutic process. Lastly, a longitudinal study of EFT therapists after engaging in self-of-the-therapist training on ableism can provide opportunities to examine long-term impact of working through negative held beliefs of PWDs.

Conclusion

The study provided information about EFT therapists experiences serving interabled couples. The results of the study provide future guidance into examining the lived experiences of interabled couples in couple therapy. Additionally, the study highlighted the importance of understanding disability-responsive practices for clients with disabilities. As the field of marriage and family therapy continues to examine areas for growth, serving interabled couples is an area to continue to expand in research and clinical practice.

References

Allan, R., & Eatough, V. (2016). The use of interpretive phenomenological analysis in couple and family therapy research. *The Family Journal: Counseling and Therapy for Couple and Families, 24*(4), 406-414. https://doi.org/10.1177/1066-480716662652

Allan, R., & Ungar, M. (2012). Couple and family therapy with five physical rehabilitation populations: A scoping review. *Australian Journal of Rehabilitation Counselling, 18*(2), 107-134. https://doi.org/10.1017/jrc.2012.13

Ali, S. (2013, March). *A disability history timeline: The struggle for equal rights through the ages.* Mersey Care NHS Foundation. https://www.merseycare.nhs.uk/media/1749/disabilityt-timeline-2013.pdf

American Association for Marriage and Family Therapy (AAMFT; 2015). *Code of ethics.* https://www.aamft.org/Legal_Ethics/Code_of_Ethics.aspx

American Counseling Association (ACA; 2014). *Code of ethics.* https://www.counseling.org/Resources/aca-code-of-ethics.pdf

American Psychological Association (APA; 2019). *Accreditation policies and procedures.* https://www.accreditation.apa.org/policies?_ga=2.86889630.781632646.1588477159-650014095.1588477159

American Psychological Association (2017). *Ethical principles of psychologists and code of conduct.* https://www.apa.org/ethics/code

Aponte, H., & Kissil, K. (2016). *Person of the therapist training model.* Taylor and Francis.

Artman, L. K., & Daniels, J. A. (2010). Disability and psychotherapy practice: Cultural competence and practical tips. *Professional Psychology: Research and Practice, 41*(5), 442-448. https://doi.org/10.1037/a0020864

Bell, C. A., Denton, W. H., Martin, G., Coffey, A. D., Hanks, C. O., Cornwell, C. S., & Priest, J. B. (2018). Learning emotionally focused couple therapy: Four clinicians' perspectives. *Journal of Couple & Relationship Therapy, 17*(1), 61-78. https://doi.org/10.1080/15332691.2017.1310638

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: A tool to enhance trustworthiness or merely a nod to validation? *Qualitative Health Research, 26*(13), 1802-1811. https://doi.org/10.1177/1049732316654870

Brault, M. W. (2012). Americans with disabilities: 2010. Current population reports, P70-131. Washington, DC: US Census Bureau. https://www.census.gove/prod/2012pubs/p70-131.pdf

Centers for Disease Control and Prevention (2019). Disability impacts all of us. https://www.cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html

Chawla, N., & Kafescioglu, N. (2012). Evidence-based couple therapy for chronic illnesses: Enriching the emotional quality of relationships with emotionally focused therapy. *Journal of Family Psychotherapy, 23*, 42-53. https://doi.org/10.1080/08975353.2012.654080

Cohen, C. B., & Napolitano, D. (2007). Adjustment to disability. *Journal of Social Work in Disability & Rehabilitation, 6*(½), 135-155. https://doi.org/10.1300/J198v06n01_08

Commission on Accreditation for Marriage and Family Therapy Education (20190. *Accreditation manual: Policies and procedures.* https://www.coamfte.org/documents/COAMFTE/COAMFTE%20Accreditation%20Manual%20Policies%20and%20Procedures.pdf

Council for Accreditation of Counseling and Related Educational Programs (2016). *Accreditation standards.* https://www.cacrep.org/for-programs/2016-cacrep-standards/

Council on Social Work Education (CSWE; 2020). *Commission on Accreditation.* https://www.cswe.org/Accreditation

Dalgleish, T. L., Johnson, S. M., Burgess Moser, M., Lafontaine, M-F., Wiebe, S. A., & Tasca, G. A. (2015). Predicting change in marital satisfaction throughout emotionally focused couple therapy. *Journal of Marital and Family Therapy, 41*(3), 276-291. https://doi.10.1111/jmft.12077

Day, M. C. (2013). The role of initial physical activity experiences in promoting posttraumatic growth in paralympic athletes with an acquired disability. *Disability and Rehabilitation, 35*(24), 2064-2072. https://doi.org/10.3109/09638288.2013.805822

Dickson, A., Ward, R., O'Brien, G., Allan, D., & O'Carroll, R. (2011). Difficulties adjusting to post-discharge life following a spinal cord injury: An interpretative phenomenological analysis. *Journal of Psychology, Health & Medicine, 16*(4), 463-474. http://doi.org/10.1080/13548596.2011.555769

Eriksen, W., Natvig, B., & Bruusgaard, D. (1999). Marital disruption and long-term work disability. *Scand J Public Health, 27*, 196-202.

Esmail, S., Huang, J., Lee, I., & Maruska, T. (2010a). Couple's experiences with men are diagnosed with multiple sclerosis in the context of their sexual relationship. *Sexuality and Disability, 28*, 15-27. https://doi.org/10.1007/s11195-009-9144-x

Fitzgerald, J., & Thomas, J. (2012). A report: Couples with medical conditions, attachment theoretical perspectives and evidence for emotionally focused couples therapy. *Contemporary Family Therapy, 34*, 277-281. https://doi:10.1007/s10591-012-9184-8

Gordon, P. A., & Perrone, K. M. (2004). When spouses become caregivers: Counseling implications for younger couples. *Journal of Rehabilitation, 70*(2), 27-32.

Hunt, B., Milsom, A., Matthews, C. R. (2009). Partner-related rehabilitation experiences of lesbians with physical disabilities. *Rehabilitation Counseling Bulletin, 52*(3), 167-178. https://doi.org/10.1177/0034355208320933

Hwang, K., Johnston, M., & Smith, J. K. (2007). Romantic attachment in individuals with physical disabilities. *Rehabilitation Psychology, 52*(2), 184-195. https://doi.org/10.1037/00905550.52.2.184

Johnson, S. M., Hunsley, J., Greenberg, L., & Schindler, D. (1999). Emotionally focused couples therapy: Status and challenges. *Clinical Psychology: Science and Practice, 6*, 67-79.

Johnson, S. M. (2019). Attachment theory in practice: Emotionally focused therapy (EFT) with individuals, couples, and families. Guilford Publication.

Johnson, S. M., & Greenman, P. S. (2006). The path to a secure bond: Emotionally focused couple therapy. *Journal of Clinical Psychology, 62*(5), 597-609. https://doi.org/10.1002/jclp.20251

Kreuter, M. (2000). Spinal cord injury and partner relationships. *The Scientific Review, 38*, 2-6.

Larkin, M., & Thompson, A. (2012). Interpretative phenomenological analysis. In A Thompson & D Harper (Eds), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners.* Jon Wiley & Sons.

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology, 3*, 102-120. https://doi.org/10.1191/1478088706qp062oa

Lauer, E. A., & Houtenville, A. J. (2018). *Annual disability statistics compendium: 2017.* Durham, HS: University of New Hampshire, Institute on Disability.

Martire, L. M. (2013). Couple-oriented interventions for chronic illness: Where do we go from here? *Journal of Social and Personal Relationships, 30*(2), 207-2014. https://doi.org/10.1177/0265407512453786

Mattlin, B. (2019). *In sickness and in health: Love, disability, and a quest to understand the perils and pleasures of interabled romance.* Beacon Press.

McLean, L. M., Walton, T., Rodin, G., Esplen, M. J., & Jones, J. M. (2013). A couple-based intervention for patients and caregivers facing end-stage cancer: Outcomes of a randomized controlled trial, *Psycho-Oncology, 22*, 28-38. https://doi.org/10.1002/pon.2046

Morris, J. (1991). *Pride against prejudice: Transforming attitudes to disability.* New Society.

Naaman, S., Radwan, K., & Johnson, S. (2009). Coping with early breast cancer: Couple adjustment processes and couple-based interventions, *Psychiatry, 72*(4), 321-345.

Najafi, M., Soleimani, A. A., Ahmadi, K., & Kamkar, E. H. (2015). The effectiveness of emotionally focused therapy on enhancing marital adjustment and quality of life among infertile couples with marital conflicts. *International Journal of Fertility & Sterility, 9*(2), 238-246. https://doi.org/10.22074/ijfs.2015.4245

Nario-Redmond, M. R. (2019). *Ableism, the causes and consequences of disability prejudice.* John Wiley & Sons, Incorporated.

National Association of Social Workers (NASW; 2017). *Code of ethics.* https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

Olkin, R. (2017). *Disability-affirmative therapist: A case formulation template for clients with disability.* Oxford University Press.

Park, J. H., Faulkner, J., & Schaller, M. (2013). Evolved disease-avoidance processes and contemporary anti-social behavior: Prejudicial attitudes and avoidance of people with physical disabilities. *Journal of Nonverbal Behavior, 27*(2), 65-87. https://doi.org/10.1023/A:1023910408854

Parker, G. (1993). Disability, caring and marriage: The experience of younger couples when a partner is disabled after marriage. *British Journal of Social Work, 23*, 565-580.

Parra-Cardona, J. R., Coórdova, D., Holtrop, K., Escobar-Chew, A. R., & Horsford, S. (2009). Culturally informed emotionally focused therapy with latino/a immigrant couples. In Rastogi, M., & Thomas, V. (ed.) Multicultural Couple Therapy (pp. 345-368). Sage Publications

Porat, O., Heruti, R., Navon-Porat, H., & Hardoff, D. (2012). Counseling young people with physical disabilities regarding relationships and sexuality issues: Utilization of a novel service. *Sex and Disability, 30*, 311-317. https://doi.org/10.1007/s11195-011-9241-5

Retief, M., & Letšosa, R. (2018). Models of disability: A brief review. *HTS Teologiese Studies/Theological Studies, 74*(1), 1-8. https://doi.org/10.4102/hts.v74i1.4738

Rivas, M., & Hill, N. R. (2017). Counselor trainees' experiences counseling disability: A phenomenological study. *Counselor Education & Supervision, 57*, 116-131. https://doi.org/10.1002/ceas.12097

Roebuck, D. C., & Reid, K. (2019). How trainee therapists experience resilience: An interpretative phenomenological analysis. *Journal of Counseling and Psychotherapy Research, 20*(3), 545-555. http://doi.org/10.1002/capr.12286

Sandberg, J. G., & Knestel, A. (2011). The experience of learning emotionally focused couples therapy. *Journal of Marital and Family Therapy, 37*(4), 393-410. https://doi.org/10.1111/j.1752-0606.2011.00254.x

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. Health Psychology Review, 5(1), 9-27. https://doi.org/10.1080/17437199.2010/510659

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* Sage.

Stake R. E. (1995) *The art of case study research.* Sage.

Stiell, K., Naaman, S., & Lee, A. (2007). Couples and chronic illness: An attachment perspective and emotionally focused therapy interventions. *Journal of Systemic Therapists, 26*(4), 59-74.

Tellier, S. A., & Calleja, N. G. (2017). Renegotiating sexuality following an acquired disability: Best practices for counselors. *Adult Life Span Journal, 16*(1), 47-59. https:/do.org/10.1002/adsp.12033

Tie, S., & Poulen, S. (2013). Emotionally focused couple therapy with couples facing terminal illness. *Contemporary Family Therapy, 35*, 557-567. https://doi.org/10.1007/s10591-013-9238-6

U.S. Bureau of Labor Statistics. (2018, May). *Marriage and family therapists.* https://www.bls.gov/oes/2018/may/oes211013.htm#(1)

U.S. Bureau of Labor Statistics. (2016, May). *Mental health counselors.* https://www.bls.gov/oes/2016/may/oes211014.htm

U.S. Department of Justice, Civil Rights Division (2009). *A guide to disability rights law*. https://www.ada.gov/cguide.htm

Wiebe, S. A., & Johnson, S. M. (2016). A review of the research in emotionally focused therapy for couples. *Family Process Institute, 55*(3), 390-406. https://doi.org/10.1111/famp.12229

Wiebe, S. A., Johnson, S. M., Lafontaine, M-F., Moser, M. B., Dalgleish, T. L., & Tasca, G. A. (2016). Two-year follow-up outcomes in emotionally focused couple therapy: An investigation of relationship satisfaction and attachment trajectories. *Journal of Marriage and Family Therapy, 43*(2), 227-244. https://doi.org/10.1111/jmft.12206

APPENDIX A

LITERATURE REVIEW

The following includes relevant literature and research related to: (a) people with disabilities, (b) interabled couples, (c) couple therapy, and (d) emotionally focused therapy (EFT). The section on people with disabilities includes common experiences of responding to the changes to quality of life (QOL) due to acquiring a disability, the history and perception of disability in the U.S., systemic barriers for PWDs in society, and mental health needs of people who acquire a disability. The exploration of interabled couples includes the description of interabled couples, the existing literature on interabled couples and common experiences, role shifts within relationship dynamics, changes to relationship satisfaction, and stressors that may lead to separation or divorce for interabled couples. I further present an exploration of couple therapy literature on serving interabled couples. Finally, the section on EFT includes outcome-based research and research on conceptual adaptations to the EFT model is presented. In examining people with disabilities (PWDs) lived experiences, understanding the historical context provides an understanding to the ways PWDs have been treated over the centuries.

Disability

Historically the disability community has experienced harsh treatment dating back to the 500 CE where views of disability were seen as an act of God (Ali, 2013; Retief & Letšosa, 2018). The religious and/or moral model of disability found in several religious traditions viewed disability as a punishment from God for sins committed by a parent or the person themselves (Ali, 2013; Retief & Letšosa, 2018). Over time, the views of disability as a sin or caused by punishment transitioned to the medical model of disability viewing PWDs as needing to be cured or "fixed" as medical advances began to emerge (Ali, 2013; Artman & Daniels, 2010). Although the medical model has improved medical interventions and symptom management for PWDs, it also contributes to stigma and prejudices about PWDs (Artman & Daniels, 2010). In the 1900s,

disabled communities were believed to be a degeneration of the human race which resulted in many children and adults being placed in confinement, segregated, and sterilized to limit reproduction (Ali, 2013). Moving into the early 1960s, disability activism led the way for improvements in legislation and protections for PWDs in the US. The disability movement began in the United Kingdom in the 60s and 70s, beginning a shift away from the medical model of disability and towards the social model of disability (Artman & Daniels, 2010; Retief & Letšosa, 2018). The view of disability under the social model shifts the "problem" from the individual to society, asserting that the disabling factor relates to societal structures that limit access and inclusion (Artman & Daniels, 2010). The social model has been utilized to explore disability not as an individual trait but a socially mediated experience (Artman & Daniels, 2010; Esmail et al., 2010b). Through many years of activism, the Americans with Disabilities Act (ADA) was passed in 1990 which prohibited discrimination on PWDs in the US (Ali, 2013; United States Department of Justice, 2009). The ADA provided opportunities and protections for PWDs, but the historical experiences of discrimination, oppression, and marginalization continue to this day (Olkin, 2017). Views of PWDs are often defined by those of the dominant group (i.e., non-disabled people; Artman & Daniels, 2010). *Disability* is defined as a person with a physical, sensory, mental, or intellectual impairment limiting their ability to fully and actively engage and participate in society on an equal basis as non-disabled people (Porat et al., 2012; United States Department of Justice, 2009). In this manuscript, I use the terms PWDs and disabled person interchangeably to signify someone with a disability identity.

During childhood development, children born with a congenital disability (e.g., deafness, blindness, cerebral palsy, physical disability, without limbs, down syndrome, etc.) regardless of culture, socioeconomic status, race, or religion face multiple systemic challenges.

Parents/caregivers play a unique role in being able to advocate for their child's needs in the community, school, and establishing a network with other families (Ostrosky & Fowler, 2011). A number of barriers, including attitudinal barriers (i.e., parental perceptions of disability, stereotyping abilities, stigma, prejudice, and discrimination), communication barriers (i.e., written or verbal content that is not accessible), physical barriers (i.e., steps, curbs, and procedures that require standing), policy barriers (i.e., denied opportunities to participate, access to process and services, and reasonable accommodations to person essential functions), and social barriers (i.e., classroom setting, access to play, and non-disabled children's understanding of PWD) impact the PWDs view of self and view of others, especially non-disabled people; Berry el at., 2015; CDC, 2019, Rogow, 2005). Often, environments are not adapted to accommodate a child's level of functioning which restricts the child's ability to learn and develop with their non-disabled peers (Hebbeler & Spiker, 2016). Children are exposed to *ableistic* (i.e. discrimination in favor of non-disabled persons) messages throughout childhood from the community, family, and schools (Tapia-Fuselier & Ray, 2019). As a result of ableist messages, disabled children may experience lower self-esteem and inhibition (Lorenz, 2008). PWDs exposed to ableist messages experience long-term impact of internalized negative messages about disability identity creating difficulties in establishing a strong sense of identity as a disabled person (Thwala et al., 2015). Although, Tellier and Calleja (2017) reported that individuals born with a disability adjusted better long-term compared to individuals who acquired a disability.

The response to being born with a disability is different than individuals who did not have a disability at birth. Given the history of societal views of disability, many ableistic views and beliefs impact those who acquire a disability later in life (Olkin, 2017). Because there are

notable differences in individual experiences depending on if the disability was congenital or acquired, the adjustment process for a person who acquires a disability warrants understanding (Halfon et al., 2012).

Acquired Disability Identity

Acquiring a disability can occur at any stage of life regardless of race, ethnicity, socioeconomic status, geographical area, religion, gender, or sexual and affection identities (Hess et al., 2016; Olkin, 2017). The occurrence of acquiring a physical disability in the US in adults is unknown, but a total of 20.5% Americans identify as having a physical disability (CDC, 2019). Individuals may acquire physical disabilities such as a brain injury, spinal cord injury, loss of limbs, stroke, paralysis, and multiple sclerosis (MS; Aruma Disability Services, 2019). After a person acquires a physical disability, the use of assistive devices varies depending on the severity and the services provided to rehabilitate the person. Furthermore, people with physical limitations may utilize assistive devices for mobility and access, such as motorized wheelchairs, manual powered wheelchairs, scooters, lifts for vehicles, crutches, or walkers (Cohen & Napolitano, 2007).

Before an individual acquires a disability, their social identities may come with privileges such as a non-disabled (e.g., access) white person with a medium to high socioeconomic status (e.g., positional power). When someone acquires a disability, an identity is lost (in this case, non-disabled) and another is gained which potentially means loss of access and power. Due to the historical views of disability, obtaining a disability identity is often experienced as negative, worthless, and less than. Concepts of stress, loss and grief, body image, stigma, quality of life (QOL), and unpredictability are often reported after acquiring a disability (Livneh & Antonak, 2005). A grief process occurs not only for the individual but also for the family and or partners,

as life plans and QOL requires reconsideration and modification (Rolland, 2018). The process of responding to a disability varies based on societal views, internalized ableism, culture, and other held identities. Pathologizing a disability may result in feeling lesser than, different from others, and damaging self-esteem (Berry et al., 2015). Experiences of denial during adjustment to acquiring a disability is common post-injury as the individual may struggle to manage the complexities of such changes (Rolland, 2018). Additionally, personal meaning and symbolism of the individual's experience after acquiring a disability may occur (Day, 2013). Newly disabled people may also report body image concerns which further complicates their adjustment and response to the disability (Sweeney et al., 2015). Due to societal ableist ideals and messages, PWDs self-concept and disability identity is challenged by an internalized ableist view-of-self such as, "something is wrong with me," which may increase stress and isolation and limited motivation to accept their new ability status (Livneh & Antonak, 2005). After acquiring a disability, the mental health status of an individual with internalized ableist views is at risk of experiencing depressive symptoms (Tellier & Calleja, 2017; Sweeney et al., 2015).

Models of Disability

Historically, several models of disability have existed going back centuries to various religious traditions. The systemic views of disabilities are essential to understand due to a long history of discrimination, oppression, and lack of access based on beliefs held by those with power and privilege (i.e., non-disabled individuals; Courtney-Long et al., 2017; Olkin, 2017). The oldest model of disability is the moral and religious model which viewed disabilities as an act of God (Retief & Letšosa, 2018). People born with or acquired disabilities were viewed as punishments from God and were condemned as evil, spiritual ineptitude, and sinful. From the moral and religious model came the medical model around the mid-1800s which viewed the

person with a disability as a medical problem, defect, deficit, abnormal, damaged, and requires fixing (Ali, 2013; Berry et al., 2015; Retief & Letšosa, 2018). The medical model of disability focuses its attention on what is broken and needs fixing in an individual (Artman & Daniels, 2010; Rivas & Hill, 2017). Although the abandonment of the moral and religious model of disability led to the emergence of the medical model, both uphold ableist views in favor of non-disabled people. Although the medical model has improved medical interventions and symptom management for PWDs, it also contributes to stigma and prejudices about PWD (Artman & Daniels, 2010). When disabled people engage with medical systems of care, messages from the medical model continue to be communicated to the disabled community promoting feelings of helplessness and hopelessness (Berry et al., 2015). Disabled people are often marginalized by society and culture which further perpetuates stereotypes and oppressive experiences (Yan et al., 2014). The emergence of the social model to disability creates a new dialogue in examining peoples' beliefs of what it means to be "disabled" (Retief & Letšosa, 2018). The social model brings forth the environment as the creation of barriers to access for PWDs. Additional models of disability such as the identity model and human rights model captures the disability activism that has continued in the US (Retief & Letšosa, 2018). In order to join in the movement for access and equality, the lived experiences of disabled people are essential to changing the systemic structures impacting their ability to engage to the fullest extent as their non-disabled peers, especially in regard to seeking and receiving mental health services (Hess & Perrone-McGovern, 2016; Retief & Letšosa, 2018).

Systemic Barriers

In 2019, the CDC conducted a study to assess disability and healthcare access which resulted in three critical findings: one in three adults with disabilities do not have a healthcare

provider; one in three adults with disabilities have an unmet healthcare need because of high cost; and one in four adults with disabilities did not have a routine check-up in the past year. The results of the CDC (2019) study demonstrate a lack of resources and services available to ensure quality care. PWDs often have increased medical expenses over their lifetime depending on the type of disability and severity (Price, 2011). Additionally, acquiring a disability can impact the individual's ability to return to work, maintain steady income, and maintain healthcare access.

PWDs may utilize specialized services, medical maintenance, assistive technology, personal care, and other necessary services to maintain QOL and engage with their environment (Artman & Daniels, 2010). Often barriers exist in accessing needed services due to limited transportation, accessibility (i.e., ramps, large print, or interpreters), and limited disability-related clinical services (CDC, 2019; Porat et al., 2012). Legislation such as the ADA (1990) requires equal access to spaces, employment, and opportunities for accommodations. Although the ADA has existed for some time, many states continue to uphold legislation which limit PWD from accessing basic environmental structures and activities. Olkin (2017) proposed that the deficit-oriented views of disability influences the slow-paced, inadequate change that has occurred on a national level, serves to further perpetuate ableist views, and prevents expanding equitable access across domains of life.

For people with physical disabilities, activities of daily living (ADL) are impacted based on the severity of the disability as it relates to the environment (i.e., employment, school, home, and community; Esmail et al., 2010a). Completion of ADLs depends on the functional limitations of the individual, such as dressing, bathing, shopping, grooming, sexual intimacy, cooking, medication management, control of bowl and bladder, employment, and driving, depending on the disability (Cohen & Napolitano, 2007). The individual's level of assistance

needed to complete ADLs can result in the need for a caregiver. Additionally, adaptations to the home, vehicle, and other necessary equipment may be needed to improve QOL and ADLs but are often not completed or obtained due to costs, health care access, and limited resources in certain communities (Parker, 1993). For example, structural changes in the home include widening doorways and showers, adding special doorknobs and fixtures, and constructing transfer stations and ramps (Cohen & Napolitano, 2007).

Sexuality

Historically, due to negative perpetuated views of disabled people, many have been perceived to not have sexual desires and often portrayed as non-sexual beings (Tellier & Calleja, 2017). Throughout human development, an individual establishes meaning and defines sexuality through their cultural background, social expectations, and personal experiences (Esmail et al., 2010a) which can leave space for misinformation. In regard to gender differences on the binary (i.e., male and female), Sweeney et al. (2015) conducted a quantitative study on 226 women with physical disabilities who identified as lesbian (n=84), bisexual (n=16), queer (n=5), and heterosexual (n=121) and studied the relationship between sexuality, body image, and physical disabilities. The results from Sweeney et al. (2015) found that women with physical disabilities' views on body image, sexual identity, and level of attractiveness were negatively viewed due to ableistic views of non-disabled women being favored. Furthermore, age predicted higher levels of acceptance of sexual abilities which may provide information about response to disability over time (Sweeney et al. 2015).

For the purposes of this section, I discuss literature within the gender binary (i.e., male and female) based on the reviewed research. Non-disabled men in the US are typically viewed as strong and independent, a view that is not extended to men with disabilities (Esmail et al.,

2010b). The role of masculinity significantly impacts men who acquire a disability, as their view of self may change from "strong and independent" to helpless or unworthy (Esmail et al., 2010b). Additionally, because of ableistic (i.e., ableism) views, societal messages about sexuality and disability can be more oppressive and limiting than the disability itself (Esmail et al., 2010b). *Ableism* includes negative, deficit-oriented views of disability shaped by the history of treatment towards people with disabilities, societal messages of "otherness," and cultural understandings which informs one's own understanding of disability (Nario-Redmond, 2019). Biases and assumptions regarding people with physical disabilities lead to the conclusion that PWDs are unable to participate sexually compared to before the onset of their disability (Tellier & Calleja, 2017). Yet, the functional ability for each individual with a physical disability varies based on the physical limitations. Women with physical disabilities may not conform to perceived oppressive images of a "normal body" and often do not have representation of various body types in media (Sweeney et al., 2015). Societal stigma for women with disabilities disrupts women's ability to reclaim their sexuality due to views of women with physical disabilities (Esmail et al., 2010b).

The Western social-cultural view of sex is privileged to heterosexual, white, single, non-disabled persons (Esmail et al., 2010b). Much of the available disability literature related to PWDs in romantic relationships is centered on heteronormative individuals and couples while inclusivity of other types of couples (i.e., gay couples) is scarce (Hunt et al., 2009). Additionally, within multicultural counseling literature, issues involving disabled people are less likely to receive exposure and discussion (Artman & Daniels, 2010). The LGBTQIA++ community with disabilities experiences various levels of marginalization and discrimination from heterosexism and ableism in addition to racism for individuals of color (Hunt et al., 2009). Views of sex and

disability for LGBTQIA++ communities are reflective of the larger ableist view. Alternatively to disabled heterosexual women, disabled women who identify as lesbian often do not have equal access to mental health support (Sweeney et al., 2015). Queer interabled couples face multiple barriers in society which impacts their ability to seek help and support (Hunt et al., 2009). Similarly, heterosexual interabled couples experience shifts to the quality of the relationship with less attention to their needs resulting in feelings of loneliness, isolation, and less physical intimacy between both partners (Gordon & Perrone, 2004). Interabled couples, straight or queer may experience varying degrees of stress or barriers as their status from non-disabled to disabled shifts or removes certain privileges previously held. *Interabled couples* is defined as one partner with a disability and the other partner identifying as non-disabled (Mattlin, 2019; Rainey, 2018).

Mental Health

Disabled people often experience self-esteem issues if exposed to oppressive and discriminatory ableist mindsets (Esmail et al., 2010b). The self-identity of people with physical disabilities is impacted when they experience rejection from society for being disabled (Livneh & Antonak, 2005). Another common experience is depressive symptoms such as feelings of isolation, helplessness, and distress that follow facing changes to one's life after an onset of a disability (Livneh & Antonak, 2005). Often times, for a PWD, accepting the loss of function takes time to adjust to new functional limitations (Day, 2013). Individuals experience an increase in stress when attempting to cope with daily activities and potential challenges (Livneh & Antonak, 2005). Denial is a common reaction in attempting to cope with the onset of a disability while also grieving the loss based on the limitations brought on by the disability (Livneh & Antonak, 2005). A search for meaning during the phase of adjustment involves reexamining personal, social, vocational, and relationship goals (Livneh & Antonak, 2005). Although

minority stress contributes to the individual's view-of-self, a minority status has also created space for psychological resilience (Sweeney et al., 2015). The support of a therapist to navigate difficult aspects of a PWD's adjustment to the disability may be necessary for overall psychological health.

Interabled Couples

The occurrence of a disability for one person within a couple impacts the physical, social, psychological, and emotional state of the person who acquired a disability, forcing changes to QOL as an individual and in relationship (Day, 2013). Esmail et al. (2010a) proposed that the presence of a disability does not impact someone's ability to maintain close partnering relationships. Limited literature in adult romantic relationship and disability is available to understand the experiences of interabled couples (Hwang et al., 2007; Parker, 1993).

Chawla and Kafescioglu (2012) examined literature on interabled couples and identified common experiences once one partner acquired a disability such as experiences of anxiety, depression, and grief related symptoms. Gordon and Perrone (2004) proposed that both partners equally experience a shift in relationship dynamics and satisfaction. A perceived threat or loss may be experienced by both partners (Rolland, 2018) and shift the views-of-self and of their partner. Additionally, Eriksen et al. (1999) identified disruptions to the relationship based on participants (n=1,115) who reported that the onset of a disability impacted both partners' ability to cope and manage changes in roles. Because early stages of shock manifest differently among couples such as numbness, anxiety, depression (i.e., feeling hopelessness, helplessness, low self-esteem), confusion, denial (i.e., unrealistic understanding of long-term changes), anger, and disorganization of roles (Cohen & Napolitano, 2007), Tie and Poulen (2013) proposed the quick onset of a disability may cause high levels of stress on the non-disabled partner, who must adapt

quickly to accommodate the changes to their partner's life. The inability to return to previous roles in relationship pre-disability might create frustration between both partners (Esmail et al., 2010a). The non-disabled partner may take on a caregiver role and responsibilities which depends on the disabled partner's disabilities and severity (Gordon & Perrone, 2004; Kreuter, 2000). Kreuter (2000) explained through a review of literature that once the role of a caregiver is assumed by the non-disabled partner, shifts in relationship between partners creates an imbalance of power, potentially placing the relationship at risk (Kreuter, 2000). The couple's systems of support, such as home care, friends, family, religion and spirituality, and support groups may change rapidly and be at risk (Cohen & Napolitano, 2007). These systems are vital to the overall health of the couple because many aspects of the relationship may change to necessitate assistance from outside support.

If support systems are not maintained or do not exist, caregivers are at risk of social isolation and significant decline in health over a period of time if not addressed (Rivera et al., 2006). Shewchuk et al. (2004) explored caregivers' experiences in the first-year of role changes after the onset of disability. Participants (n=60) reported susceptibility to problems with physical health, increased stress, anxiety, and depression. One reason for increased mental health symptoms based on Shewchuk et al. (2004) findings is caregivers are vulnerable to the ongoing care demands in supporting their disabled partner through an array of issues and changes. However, the experience of caregivers is not mutually exclusive. For example, Chayaput et al (2014) conducted a quantitative correlation study on (n= 87) caregivers and (n=87) survivors of a traumatic brain injury (TBI) to evaluate coping skills and health problems of the caregiver during post-acute rehabilitation phase of recovery (i.e., one month after discharge from hospital). Chayaput et al (2014) found that caregivers coped with their new roles by accepting their reality

after some time to adjust. Additionally, results revealed that married couples adjusted to obligations better than did single or separated caregivers (Chayaput et al., 2014). Lastly, Chayaput et al. (2014) showed that caregivers who did not experience depression or a sense of burden with the demands of caring for their disabled partner were more effective in assisting with their partners' recovery process. Considerations for at-risk couples are described by Kreuter (2000), who examined several studies on interabled couples with spinal cord injury's (SCIs) and found characteristics that determined high risk relationships such as young couples, couples of color, couples with no children, and history of divorce. The characteristics described in Kreuter (2000) may lead to substantial differences in interabled couples' ability to cope and successfully re-establish their relationship.

Caregiver Role

Once a disability is acquired, interabled couples encounter the complexities of care options which varies based on the limitations from the disability. Many interabled couples jointly or individually choose to assign the non-disabled partner as the caregiver to aid in managing their disabled partner's needs. The choice to shift into a caregiver role requires considerations of the couples understanding of roles in relationship based on their culture, society expectations, family, and other influences (Gordon & Perrone, 2004). Differences exist between caregivers and their roles based on societal views of gender (i.e., male or female; Rivera et al., 2006). Queer interabled couples must negotiate their roles, power, and autonomy within their relationship at the time a disability is acquired (Hunt et al., 2009). In a heterosexual relationship, men may experience difficulties adjusting to caregiver role for their female partner with a disability (Rivera et al., 2006). Additionally, in heterosexual relationships, women caregivers reported having friends and family for support, whereas men appeared to manage caregiver

responsibilities internally on their own with minimum support (Gordon & Perrone, 2004). In heterosexual couples, the disabled female partner often expressed more sadness or guilt in being a burden towards their male partners (Parker, 1993). These changes in gender roles create a disparity to expectations set by societal norms and heteronormative standards. In Gordon and Perrone's (2004) literature review, they found few studies examined gender differences in caregiver's responsibilities and process of adjustment. Often, the role shifts in the relationship may not be a huge contributor to stress on the relationship dynamic but experiences of overload for the caregiver can occur (Parker, 1993). As caregivers adjust to their new roles, challenges to managing physical health necessitates the expansion of care to potentially include a care attendant (i.e., paid personal care, family, or friend; Chayaput et al., 2014). The caregiver may benefit from assistance managing both emotional and physical obligations involved in caring for a partner with a disability (Gordon & Perrone, 2004). Additionally, shifts in responsibility of physical tasks from the disabled partner to their non-disabled partner require re-balancing the relationship in other ways such as, providing emotional support and comfort (Tie & Poulen, 2013). During the adjustment process, the disabled partner's capacity to meet their non-disabled partner's needs creates additional layers of pressure. If the disabled partner demonstrates equal emotional support, relationship satisfaction increases even with changes in physical abilities and responsibilities (Gordon & Perrone, 2004). In addition to establishing new roles and responsibilities in the relationship, finances become an additional stressor for interabled couples if one person is unable to maintain current employment or return to work.

Financial Shifts

The cost for disability management and maintenance of finances creates additional stressors for interabled couples to manage. Depending on the limitations of the acquired

disability, the disabled partner's employment has the potential to shift in duties or require termination of employment. Changes to employment after a person has acquired a disability can be reduced hours, family medical leave, laid-off, or leaving the position. Potential unemployment may significantly impact the couple's financial stability if accommodations for the job are not provided. In the US, the number of unemployed PWDs in 2019 was 7.3% with 32% of PWDs working part-time (US Bureau of Labor Statistics, 2019). The CDC and Prevention (2017) estimated that a PWD age 21-64 has, on average, monthly earnings of $1,961 compared to a non-disabled person earning $2,724. The monthly earnings may vary depending on the individual's functional limitations and position held in their employment. The change in earnings can negatively affect the stability of a household after an individual acquires a disability (Rolland, 2018). The result of financial losses may require the non-disabled partner/caregiver to become the primary income holder in the couple. Both partners will require re-adjusting their finances as well as new roles and changes in family structure to stabilize the relationship (Gordon & Perrone, 2004).

Divorce/Separation

Interabled couples may be at risk for relationship distress leading to potential divorce/separation. Divorces may occur after an unexpected significant event to a partner such as, severe car accident, stroke, TBI, work injury, illness, etc. (Price, 2011). In Kreuter's (2000) review of 11 studies on caregivers (i.e., non-disabled partners) and partners with acquired SCIs found several studies reporting a divorce rate between 8% to 48%, indicating a large discrepancy in reporting. Still, limited data exists with details in the number of couples that experience separation or divorce due to a partner acquiring a disability. In many cases, divorce after a partner acquires a disability becomes more stressful to manage with many significant changes

occurring (i.e., physical limitations, employment, community engagement; Price, 2011). In some instances, the actual separation would result in financial constraints for one or both partners which would create additional limitations to separating (Parker, 1993).

A variety of circumstances, including stage of life, onset of a disability, and health of the relationship prior to one partner acquiring a disability can influence relationship outcomes (Smart, 2019). The couples' level of adaptation to the disability can be a strong predictor of relationship success (Gordon & Perrone, 2004). In order for successful interabled couples to maintain their relationship, additional conversations about their relationship and future together are necessary. However, often, couples do not communicate about their fears or concerns as partners often filter their communication to prevent pain or discomfort (Esmail et al., 2010a; Rolland, 2018). Many aspects impact the success of a relationship after acquiring a disability. For example, Hunt et al. (2009) conducted a qualitative phenomenological study by interviewing women with physical disabilities (n=25) and identified themes through consensus, including one theme as limited support provided to the non-disabled partner through transition and recovery. Additional themes from Hunt et al's (2009) study related to evolving partner roles, sexuality issues, and negotiating the influence of the disability. Additionally, the disabled partner's internalized messages of not being attractive or worthy can begin to establish a cycle of disconnection between partners (Esmail et al., 2010a). Fear of rejection may result in dissolving the relationship as to not burden the non-disable partner (Esmail et al., 2010a). These instances occur when the disabled partner has a low self-esteem (Parker, 1993). For example, Parker (1993) found through a qualitative study on 21 couples (n=42) that when one partner acquired a disability during marriage, a common concern is the expectations partners have for one another (Parker, 1993). Managing personal biases and assumptions of disabled people is vital to the

ability of both partners to accept the disability (Artman & Daniels, 2010). Couples engage in various coping strategies and, without proper attention, can result in separation or divorce. Interabled couples experience new systems of care that require communication for sustained connection. Through a phenomenological approach, Esmail et al. (2010a) captured the importance of open communication through interviewing four couples (n=8) and found that open communication was a key element to the success of their relationship.

If support within the relationship was lacking before the disability onset, the adjustment may be more difficult without the partners support and open communication (Parker, 1993). Couples must navigate new environmental systems such as transportation, medical, financial support, and rehabilitative services. The non-disabled partner experiences additional challenges and environmental barriers due to accessibility concerns over their disabled partner creating a reduction in the amount of activity done outside the home (Esmail et al., 2010a). Often the non-disabled partner experiences increased levels of anxiety in planning for outing with their disabled partner due to increase in managing predicaments (Esmail et al., 2010a). The stressors of planning to manage environmental barriers also includes the interabled couple's ability to balance their sexual relationship.

Stressors

Based on the functional limitations of an individual, experiences vary in their symptoms and level of sexual activity (Esmail et al., 2010a). The disabled partner's ability to engage sexually are impacted based on the type of disability, severity, and level of functioning. The disabled partner experiences significant anxiety regarding being desired and their ability to sexually perform (Janus, 2009). Similarly, in the event of sexual desire decreasing from the disabled partner, the non-disabled partner may experience not being attractive when their

disabled partner's desire for sexual intimacy has reduced (Esmail et al., 2010a). The insecurities both partners experience may create negative cycles of interaction. Parker (1993) found that couples reported a shift in their physical relationship, including a few couples reporting being unable to experience a satisfying sexual relationship. Additionally, Hunt et al. (2009) found partners struggling to find positions that worked well due to physical limitations from the disabled partner, especially when pain was a common factor. Couples are often uninformed about methods to modify their sexual intimately after an acquired disability (East & Orchard, 2014; Parker, 1993). Esmail et al. (2010a) reported men benefited from hearing their non-disabled partner accept their disability which increased confidence to engage in sexual activities. Interabled couples have an opportunity to navigate the disabled partner's pain and physical limitations which provide opportunities to explore alternative sexual expressions and possible feelings of body shame, embarrassment, and insecurity (Parker, 1993). Once the sexual insecurities are dealt with, couples can begin to engage sexually using various methods such as sex toys, positions, and alternative forms of contact (Esmail et al., 2010a). Certain benefits of utilizing sexual aids include increased stimuli for affected areas where decreased sensation was experienced (Esmail et al., 2010a). In addition to these physical changes, there are social and emotional changes as well. For instance, PWDs who are in romantic relationships may find that the disability can create disconnection between a couple attempting to return to their QOL before the disability (Rolland, 2018). Given the extent of changes an interabled couple experiences after one partner acquires a disability, further examination of available therapy for couples is warranted.

Couples Therapy

Couple therapy originated in Germany in the 1920s, and around the 1930s the US opened its first institute of marriage counseling (Gurman & Fraenkel, 2002). In the early history of couple therapy in the US, the treatment format varied and often consisted of only partners being seen separately (Gurman & Fraenkel, 2002). The approaches to couple therapy most popular in the 1960s were psychoanalytic and psychodynamic approaches to marital therapy (Gurman & Fraenkel, 2002). The research from Gottman and Silver's (1999, 2015) work with couples provided the foundation for understanding couple therapy and ways to enhance the therapeutic experience. During the 1980s, Behavioral Martial Therapy and EFT were theory-based approaches that attracted attention in the US (Gurman & Fraenkel, 2002). A meta-analysis by Dunn and Schwebel (1995) examined 19 studies comparing CBT, behavioral therapy and Insight-Oriented Marital Therapies (i.e., examining partners' experiences in their family of origin and influence of family background) which included EFT (Beasley & Ager, 2019). The findings from Dunn and Schwebel (1995) concluded Insight-Oriented Therapies, such as EFT, were more effective at improving relationship functioning than CBT or Behavioral Therapy (Beasley & Ager, 2019). EFT continues to be a popular couple therapy approach to improving relationship satisfaction and secure connection.

Currently, around 80% of therapists in private practice provide couples therapy which includes LMFT, LPC, and other licensed professionals (Open Counseling, 2020). With 80% potentially serving couples, the number of therapists trained in an evidence-based approach is uncertain. With a high number of professionals providing couples therapy, there are considerations for when couples make the decision to seek services. MidAmerica Nazarene University (2017) surveyed 1,000 engaged, married, and divorced people and found that 49% of

respondents reported having attended couples' therapy. Additionally, they found that couples married within one to five years were more likely to attend marriage counseling with communication being ranked the highest as the reason to attend couple therapy. Other reasons couples reported for attending couple therapy included extramarital affairs, finances, and parenting issues.

In examining the interabled couple experience in seeking couple therapy, much of the couple's literature with disability, sexuality, spousal care, and aging often focus on one individual's perspective (Torge, 2013). Specifically, literature is limited in situations in which a partner acquires a disability while in a non-disabled couple relationship. Additionally, experiences of therapists serving interabled couples in limited. Lastly, there is no evidence-based practice for clients with disabilities (Artman & Daniels, 2010) within couple therapy or individual therapy.

Interabled Couples Therapy

Within the field of rehabilitation counseling, rehabilitation counselors are trained to serve PWDs in individual counseling with a variety of focuses (i.e., vocational rehabilitation, career counseling, job placement, and individual therapy). CACREP programs for rehabilitation counseling have no specific standards for coursework related to interabled couple counseling (2016). Currently, there is no evidence-based approach to serving interabled couples in couple therapy (Sweeney et al., 2015). Some recommendations for working with interabled couples are discussed in disability, multicultural counseling, and couple therapy literature which is described below.

Although the literature regarding interabled couples is limited, Livneh and Antonak (2005) recommended an eclectic approach to counseling clients with disabilities/chronic illness

to address various aspects of the recovery process. Additionally, Parker (1993) recommended a holistic approach to counseling in working with interabled couples to address the couples spiritual, emotional, and physical aspects of sexuality. Therapeutic interventions supplement rehabilitative treatment of a disability to support both partners in the adjustment process (Martire, 2013). Collaboration between the therapist and other medical/health providers serving the client should be considered to treat the client holistically (Tellier & Calleja, 2017).

Factors for therapists to consider when beginning to serve interabled couples are the couple's quality of relationship before the onset of disability, severity of disability, type of disability management, and supportive services in place (Gordon & Perrone, 2004; Parker, 1993). Specific factors may include the quality of relationship prior to the disability, assumptions and biases each member of the couple have about the disability community, impact of assumptions on their view of each other after the onset of the disability, type of QOL present before and after the disability, and availability of services to support the disabled partner's needs. An exploration of the caregiver's self-care and available resources provides additional information about the extent of support accessible to the couple (Gordon & Perrone, 2004). Rivas and Hill (2017) interviewed graduate level students (n=10) regarding their experiences serving clients with disabilities and found that therapists using an integrated framework focused on systemic issues in working with disabled people such as assisting the couple in navigating financial resources, assistive technology, rehabilitative services may enhance therapeutic outcomes. Lastly, Hunt et al (2009) and Martire (2013) recommended therapists explore a couple's ability to advocate for their needs as a central role in serving interabled couples.

Aside from specific approaches, therapists working with interabled couples are encouraged to understand themselves and their knowledge of disability. Effective clinicians work

towards increasing awareness about PWDs as well as self-work on eliminating internalized stigma, biases, and beliefs of sexuality and disability (Artman & Daniels, 2010; Tellier & Calleja, 2017). Unaddressed therapist's assumptions are likely harmful to the therapeutic relationship as the therapist may further perpetuate ableistic ideals in society (ACA, 2014). In Gordon and Perrone (2004) review of literature, a common experience reported by clinicians with unresolved biases is the perception that caregiving is a negative experience which influences the messages communicated to clients. In order to further understand therapists' experiences treating interabled couples, there appears to be a need to understand their clinical training and current approaches utilized in serving interabled couples.

Clinical Training

In four accrediting mental health profession educational bodies (i.e., CACREP, APA-CoA, COAMFTE, CSWE), standards are implemented into the development of coursework with the goal of producing qualified professionals into the field. Based on the standards of non-rehabilitation counseling programs, such as mental health counseling, clinical social work, clinical psychology, and marriage and family therapy, programs require a completion of an advanced degree with credit hours ranging from 60-93. Post-graduation professionals obtain provisional licenses and must complete clinical supervised hours that vary based on profession and state the individual resides. Upon completion of the required hours for full licensure, maintenance of licenses is achieved through the fulfillment of continuing education credits (CEUs) meant to enhance the professional's knowledge, skills, and abilities.

Within the mental health profession, there is a disparity in diverse professionals serving minoritized and marginalized clients (Larrison & Schoppelrey, 2011), including PWDs. In 2017, a total of 73% of counselors in the field identified as female and 27% male (Census Bureau,

2017). The majority of counselors in the US identified as white (61.9%), second largest as Black/African American (19.4%), and the remaining 19% as Asian, Hispanic/Latinx, and other (Census Bureau, 2017). Ability status was not reported by the Census Bureau (2017) survey resulting in a lack of attention and representation for ability status. Although graduate training programs emphasize multicultural training, within CACREP counselor training programs limited content related to counseling PWDs is covered in the coursework (Rivas & Hill, 2017). With limited training in disability, conceptualization of disability may be framed according to the medicalized narratives with an increase in stigmatized views of experiences of people with disabilities (Rivas & Hill, 2017).

Given the limitations to clinical training in serving interabled couples, examining one evidence-based approach such as EFT has the potential to support interabled couples. Evidence for the potential application to interabled couples comes from a few EFT studies demonstrating improvements in relationship distress from an onset of a disability (Chawla & Kafescioglu, 2012; Fitzgerald & Thomas, 2012; Naaman, 2009; Wiebe & Johnson, 2016).

Emotionally Focused Therapy

In the 1960s, the field of psychology was fueled by psychoanalytic theory and around that time, another school of thought began to emerge, attachment theory. John Bowlby (1969/1982) believed early parent-child relationships set the foundation for healthy relationship development which differed from Freud's psychoanalytic theory. Bowlby's work led to the development of attachment theory which is grounded in the belief that everyone has a survival need for a safe emotional connection with a loved one (Bowlby, 1969; Johnson & Greenman, 2006). As relational beings, Bowlby (1969/1982) explained that internal working models (IWMs) of self and others which developed based on the individual's history and experiences

with attachment figures (Brubacher, 2017). Although attachment theory centered on parent-child relationship, Bowlby began to conceptualize its application for adult attachment, but did not fully develop this conceptualization (Bowlby, 1982). In the 1980s, the work of Sue Johnson and Leslie Greenman (1988) explored the understanding of adult attachment and romantic relationships further leading to the development of EFT. EFT applied attachment theory as a foundation and incorporated humanistic, systemic, and experiential theories to provide a guide for treating couples in distress (Johnson & Greenman, 2006; Johnson, 2019).

Table A.1

EFT Stages and Steps

Stages	Steps
Stage 1: The De-Escalation of Negative Cycles of Interaction-Relationship Stabilization	• Step 1: Creating an alliance and delineating conflict issues in the core attachment struggle. • Step 2: Identifying the negative interactional cycle where these issues are expressed. • Step 3: Accessing the unacknowledged emotions underlying interactional positions. • Step 4: Reframing the problem in terms of negative cycle, underlying emotions, and attachment needs. The cycle is framed as the common enemy and the course of the partners' emotional deprivation and distress.
Stage 2: Changing Interactional Positions	• Step 5: Promoting identification with disowned attachment emotions, needs, and aspects, of self and integrating these into relationship interactions. • Step 6: Promoting acceptance of each partner's experience and new interactional responses. • Step 7: Facilitating the expression of needs and wants and creating emotional engagement and bonding events that redefine the attachment between partners.
Stage 3: Consolidation and Integration	• Step 8: Facilitating the emergence of new solutions to old relationship problems. • Step 9: Consolidating new positions and new cycles of attachment behaviors.

Note. Adapted from Johnson (2020).

Therapy requires a roadmap that guides the therapist to help people change and reorganize the client's view of self and others (Johnson, 2019). Johnson (2019) suggested that EFT offers a map and guide to understanding relational processes and clear therapeutic goals for couples, individual, and family therapy. EFT therapists work to provide three key factors for security in attachment bonds: accessibility, responsiveness, and engagement (A.R.E.; Brubacher, 2017; Johnson, 2019). EFT concentrates on empathic understanding of couple's immediate experience with interest in emotions and frame of references (Johnson, 2004). Within the EFT model, the roadmap to healing and change follows three stages: (1) the de-escalation of negative cycles of interaction-relationship stabilization, (2) changing interactional positions, and (3) consolidation and integration (Johnson, 2019; Johnson, 2020). Through this three-stage process, nine-steps offer a guide to move the couple through each stage of EFT with each step creating a safe and secure bond within the couple (see Table 1). The creation of a secure bond between the couple is the ultimate goal of EFT (Fitzgerald & Thomas, 2012; Johnson, 2004).

Outcome Based Research

EFT is an empirically validated approach to couple therapy (Dalgleish et al., 2015; Johnson & Greenman, 2006) with over 30 years of research. Training and research in EFT have expanded to various countries around the world which continues to support the effectiveness of EFT as an evidenced-based model. Among the various couple therapy approaches, a meta-analysis of 9 randomized controlled trials (RCTs) found EFT demonstrated a 70-73% improvement rate for relationship distress in couple therapy (Johnson et al., 1999). Dalgleish et al. (2015) examined the changes in marital satisfaction using EFT by using hierarchical linear modeling to analyze the data of couples (N=32) and found that they improved by 64.5% in relationship satisfaction by the end of treatment. Although the percentage from Dalgleish et al.

(2015) and Johnson et al. (1999) differ slightly in relationship satisfaction, the findings continue to support EFT as an effective approach to couple therapy. Longitudinal studies have provided vital information to the efficacy of EFT and impact on relationships post-treatment. Wiebe et al. (2016) conducted a 24-month follow-up after receiving EFT treatment and examined the relationship satisfaction. Results from the study indicated that 46.4% (n=13) of couples improved in relationship satisfaction at 24-month follow-up of receiving EFT. Compared to traditional behavioral couple therapy approaches, findings at 24-months demonstrated a decrease in relationship satisfaction (Wiebe et al., 2016).

Over time, various researchers have conducted meta-analyses on EFT to examine the effects of various RCTs in EFT (Beasley & Ager, 2019). In Dunn and Schwebel's (1995) initial meta-analysis comparing CBT, behavioral therapy, and Insight-Oriented Therapists, they concluded that Insight-Oriented Therapists such as EFT were more effective at improving relationship functioning than CBT or Behavioral Therapy. Additionally, Wood et al. (2005) focused on various behavioral interventions that included EFT and examined the effectiveness on marital distress. Wood et al.'s findings (2005) indicated Behavioral Therapy was less effective than EFT at treating moderate relationship distress. Another example of utility of EFT is Greenman and Johnson's (2013) literature review examination of nine studies in EFT with results of successful outcomes in regard to couples being more open, engaged, responsive, and having more emotional depth. Lastly, a meta-analysis by Beasley and Ager (2019) narrowed 902 articles down to nine studies that met the inclusion criteria. The findings include a Hedges g score of 2.09 effect size (Cohen, 1988) as well as tentative support of improvements maintained after treatment (Beasley & Ager, 2019). The research in EFT is ongoing and continues to expand the populations being examined.

RCTs and quasi experimental designs (QEDs) continue to be conducted to examine the application of EFT with diverse populations such as Middle Eastern couples (Najafi et al., 2015), couples dealing with infertility (Najafi et al., 2015), women dealing with breast cancer (Naaman, 2009), and end-stage cancer (McLean et al., 2013). Additional RCTs in EFT have also focused on survivors of childhood trauma (Dalton et al., 2013) and individuals with depression (Dessaulles et al., 2003). An expansion of RCTs in EFT with diverse couples is recommended as the target group (Beasley & Ager, 2019). The increase in research in EFT has also expanded to explore the experiences of therapists completing EFT trainings and supervision. The rationale of exploring therapists' experiences is due to limited information known about the overall training outcomes for therapists both quantitatively and qualitatively (Bell et al., 2018).

Training

The Centre for Excellence in Emotionally Focused Couple Therapy (ICEEFT) was established by Dr. Sue Johnson and other colleagues to expand efforts to train clinicians around the world in EFT (Bell et al., 2018). Over time, ICEEFT established standards for therapists seeking to obtain EFT certification and EFT supervisor certification (Koren et al., 2020). The standards for certification require several steps and require intensive training, supervision, and practice to master the process (Sandberg & Knestel, 2011). Trainings for EFT are offered to graduate students in a variety of mental health professions, religious leaders, academicians from different clinical backgrounds, and professionals around the world. Over the last 10 years, research has been conducted to examine the experiences of therapists completing EFT training to identify training strengths and gaps (Sandberg & Knestel, 2011). For many years, trainings were provided, but empirically little was known about the training outcomes in EFT for therapists (Montagno et al., 2011).

Training in EFT is considered rigorous, with the first training in EFT a 4-day externship (28-30 hour training; Bell et al., 2018) provided by a certified EFT trainer that consists of experiential and didactic work (Montagno et al., 2011). In the externship, participants learn about attachment theory and the EFT model and clinical techniques in working with couples (Montagno et al., 2011). Further, participants observe recorded EFT therapy sessions, discuss clinical cases, and engage in role-plays (Montagno et al., 2011). The goals for the externship outlined by ICEEFT (2009) include: understanding couples' distress within attachment theory, assist couples in experiencing corrective emotional experiences, create new bonding events between partners, and work through therapists held beliefs and values (Sandberg & Knestel, 2011). Following the externship, therapists continue to four 2-day core skills training (48 hours) provided by a certified EFT trainer (Bell et al., 2018). The core skills trainings are more in-depth and advanced trainings in understanding the three stages of the EFT model and direct consultation on client cases. Additionally, ICEEFT road to certification requires therapists to obtain supervision by a certified EFT supervisor for a total of 8 supervised hours (Bell et al., 2018; Sandberg & Knestel, 2011). The supervisors work with the therapist and incorporate aspects of "self-of-the-therapist" in which the therapist explores emotional or psychological barriers to engage fully in the EFT model (Aponte & Kissil, 2016; Sandberg & Knestel, 2011).

Evaluating the EFT trainings and experiences of therapists became a focus over the last decade to assessing effectiveness and outcomes of completion of training. A few studies are highlighted that speak to the experiences of therapists who participated in EFT trainings. The first study by Sandberg and Knestel (2011) conducted a quantitative study with open-ended questions that examined the experience of therapists learning EFT that included n=122 clinicians with the majority of the participants being white woman (90%). The demographics information

from the 122 participants of the study indicated that 50% of the participants identified as serving couples (Sandberg & Knestel, 2011). The participants identified learning EFT through ICEEFT trainings (i.e., externship, core skills training), attending a lecture, or reading a book (Sandberg & Knestel, 2011). Results from Sandberg and Knestel (2011) indicated that learning EFT led to being more empathic, validating, and compassionate towards clients. Additionally, Sandberg and Knestel (2011) reported participants were positively impacted in developing further insight with personal traumas and attachment injuries. Lastly, therapists utilizing EFT reported a deeper level of engagement with couples that goes beyond conflict through content and address underlying needs (Sandberg & Knestel, 2011). The findings from Sandberg and Knestel (2011) provide valuable information about the personal and professional impact from practicing EFT.

Bell et al. (2018) conducted a qualitative study exploring perspectives of four participants learning EFT. Results from the study identified that all participants reported gaining insight, improving relationships, and applying attachment principles in other settings (Bell et al., 2018). Within the themes, participants reported barriers in learning a new model and shared feeling stuck and experiencing a lack of examples to follow (Bell et al., 2018). The comprehensiveness of EFT trainings provided participates an opportunity to fully learn and apply the model (Bell et al., 2018). A limitation of the study was the sample size and a homogenous sample. At 6-year follow-up, some of the participants reported being shaped personally and professionally by EFT (Bell et al., 2018). Future research is needed to explore diverse voices and their experiences working with EFT as a model (Bell et al., 2018).

Lasty, Montagno et al. (2011) conducted a quantitative study (n=76) by providing pre and post assessments to identify changes in perception. Participants who completed the training reported having been impacted both personally and professionally (Koren et al., 2020; Montagno

et al., 2011). The findings from the studies described above report the impact on therapists personally and professionally in learning an attachment-based model for working with couples. The process for completing the trainings requires financial considerations as each component has a different financial requirement based on location and trainer.

Barriers

In summarizing the research in EFT, multiple authors recommend conducting research with more diverse participants in both quantitative and qualitative methods (Bell et al., 2018; Dalgleish et al., 2015; Koren et al., 2020; Wiebe et al., 2016). Several studies mentioned a limitation in samples being largely identifying as white, heterosexual, well-educated, and high-earning families (Dalgleish et al., 2015). In addition to samples being homogenous in race and sexual orientation, disability status is also a limitation in many studies as it is not included in demographics of therapists or clients (Cloutier et al., 2002; Wiebe et al., 2016). Lastly, another barrier to training experiences are the examples utilized to demonstrate skills, often they are heteronormative non-disabled examples (Wiebe et al., 2016).

EFT with Interabled Couples

The use of an evidence-based approach such as EFT to treat couples provides therapists a foundation of research to support effectiveness of therapy. In understanding the EFT model and its flexibility, its application to working with interabled couples has shown effectiveness in supporting both partners. For example, Cloutier et al. (2002) applied EFT to couples with chronically ill children and completed a 2-year follow-up after treatment. The findings from Cloutier et al. (2002) indicated that at 2-year follow-up 81% (n=13) of couples-maintained treatment effects and 61% (n=8) of couples improved or recovered from their level of distress at

2-year follow up. Although the couples were not considered interabled, they navigated heightened stress of managing their child's chronic illness.

In considering EFTs application to interabled couples, proposed culturally informed applications of EFT have been extended to conceptualize Latinx couples (Parra-Cardona et al., 2009). EFT has been conceptualized to provide recommendations to working with intercultural couples (Linhof & Allan, 2019). Lastly, Allan and Johnson (2017) worked to expand the conceptualization of EFT to focus on working with gay couples. Due to the flexibility of the model, applying EFT with interabled couples could yield promising results of ways therapists can incorporate quality disability-responsive care.

The amount of literature focused on cultural diversity within couple and family therapy is extremely limited (Linhof & Allan, 2019). Inclusive research regarding diverse couples and the service delivery of couple therapy promotes progress toward social justice and equity (Spengler et al., 2019). Couple therapy can be an avenue to co-create and strengthen relationships through safe and secure connection (Spengler et al., 2019) even for interabled couples. Limited studies provide opportunities for inclusion of diverse identities within outcome research such as disability or sexual minorities (Spengler et al., 2019). EFT can be extended to serve diverse relationships as core components of EFT provide the framework to adapt to the needs of clients' identities (Parra-Cardona et al., 2009).

Mental health professionals have a duty to understand experiences of interabled couples and identify effective methods of intervention (Ghedin et al., 2017). Wherein the goal of EFT is to create, re-establish, and strengthen attachment bonds between couples with or without disabilities (Ghedin et al., 2017), EFT may be particularly well-suited for serving interabled

couples. Understanding experiences of therapists serving interabled couples is necessary to understand the gaps in trainings and supervision in supporting these couples.

Conclusion

A formalized evidence-based practice for clients with disabilities is not currently identified for couples counseling (Artman & Daniels, 2010). Factors for interabled couples which may impact their romantic relationships are the type of disability, limitations, relationship prior to disability, adjustment to disability, and support system available (Hwang et al., 2007). Often access to services are barriers due to limited transportation, accessibility (i.e., ramps, large print, interpreters, etc.), and disability-responsive clinical services (Porat et al., 2012). Given the many factors and changes to the couple's dynamic, this study seeks to gain an in-depth understanding of the ways couple therapists trained in EFT work with interabled couples. A depth of knowledge is known about the benefits of EFT, but little is known about EFT therapists' experiences working with interabled couples.

APPENDIX B

METHODS

EFT is an evidence-based approach, yet there are components of the EFT therapist experience that remain unknown. Specifically, there is a gap in knowledge respective to EFT therapists' experiences working with interabled couples. In order to contribute to this gap in the scholarship, I conducted a qualitative study that investigated this phenomenon. I determined that a qualitative method of inquiry was the most appropriate approach to answer my research question. Specifically, I utilized Interpretative Phenomenological Analysis (IPA) to address my research question. IPA is a qualitative research method centered in exploring the meaning people give to their lived experience or process (i.e., lifeworld; Miller et al., 2018; Smith et al., 2009; Smith, 2011). The choice of IPA as methodology for this study was based on my idiographic approach to centering the participants' meaning making experiences of providing therapy to interabled couples. IPA draws on three key areas of philosophy of knowledge: Phenomenology, hermeneutics, and idiography which combined provide a focus on a particular to the shared and from the descriptive to interpretative analyses (Allan & Eatough, 2016; Smith et al., 2009; Smith, 2011). IPA is an inductive approach that centers the participants as experts in their lived experiences and are selected based on their knowledge (Allan & Eatough, 2016).

Another theoretical underpinning in IPA is hermeneutics which is a method for interpreting text and meaning (Allan & Eatough, 2016). I leaned on hermeneutic practices in conducting a detailed analysis of the text from participant interviews (Smith et al., 2009). I utilized the hermeneutic circle in my interpretation of the data by examining the part to the whole, the single word (i.e., emphasis from participant) to the sentence the word was embedded in (Smith et al., 2009). I moved back and forth through the data throughout the analysis process of one single case to the collective of cases.

The goal of IPA is to explore an individual's meaning constructed through experiencing themselves and their world (Dickson et al., 2011). Due to the idiographic nature of IPA, it allows for an in-depth single-case analysis for each participant (Miller et al., 2018). I relied on idiographic principles in examining in detail one participant's case until a gestalt had been achieved (Smith, 2004) before moving onto the next participant. The in-depth analysis of one participant case at a time provided an opportunity to learn a great detail about the participant and their responses in the interview. This process allowed the 'essence' of the participant's case to bring the particulars of the case to the shared experiences of other participants later in the analysis process (Smith, 2004). Larkin et al. (2006) highlighted that IPA is committed to two processes including giving voice to participants (phenomenological) and contextualizing those voices from a psychological perspective (interpretative). For the current study, the use of the ableism theoretical framework (Nario-Redmond, 2020) emerged during the data analysis process and was informed by literature and participant narratives.

Within couples and family therapy research, IPA can apply to clients, therapists, and researchers to explore phenomena of service delivery or development of programs (Allan & Eatough, 2016). Utilizing a qualitative IPA methodological approach to examine EFT therapists' accounts served to provide rich, meaningful data, and ultimately, enrich therapeutic practices as it relates to serving interabled couples. For the reasons outlined above, I applied IPA to inform the design of the qualitative study and data analysis processes. The research was guided by the following research question. How do EFT Therapists make sense of their lived experience working with interabled couples in couple therapy?

Operational Definitions

For this study, I use the following operational definitions of key terms.

- *Interabled couples* is defined as one partner having a physical disability and the other partner identifying as nondisabled (Mattlin, 2019; Rainey, 2018)
- *Emotionally focused therapy (EFT)* is based on a theory of relationship created by Sue Johnson and Leslie Greenberg to reduce couple distress through creating safe and secure emotional bonds between partners (Beasley & Ager, 2019; Johnson, 2019). EFT integrates humanistic experiential perspective (i.e., Rogers, 1951; Perls, 1973) and systems theory, as well as grounding in attachment theory (Bowlby 1988)
- *Disability* – is defined as a person with a physical, sensory, mental, or intellectual impairment limiting their ability to fully and actively engage and participate in society on an equal basis as non-disabled people (Porat et al., 2012; United States Department of Justice, 2009)
- *Ableism* includes negative, deficit-oriented views of disability shaped by the history of treatment towards people with disabilities, societal messages of "otherness," and cultural understandings which informs one's own understanding of disability (Nario-Redmond, 2019).

Participants

IPA recommended purposive sampling to capture the meaningful experiences of a homogenous group's experience with a specific phenomenon (Dickson et al., 2011; Smith et al., 2009; Smith & Osborn, 2003). I recruited participants based on the following inclusion criteria: (a) a non-rehabilitation counseling master or doctoral level therapist with a degree in mental health counseling or related degree, (b) licensed to practice, such as: licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), licensed clinical social worker (LCSW), licensed clinical psychologist (PsyD), or other related license, (c) currently provide or have provided services to at least one interabled couple, (d) have completed advanced training in

EFT (i.e., externship and core skills) or certified by ICEEFT as an EFT therapist, supervisor, or trainer (See Table 2).

To address the research question, Smith et al. (2009) suggests for large studies that it be no less than 8 participants, while also ensuring that the sample size is not "too large" as it may impact data analysis. I aimed to have a sample size between 8-10 participants and completed the study with 10 participants. All participants in the study were identified through ICEEFT membership list. All participants in the study were certified EFT therapists which meant they fulfilled the requirements set forth by ICEEFT to perform and provide EFT couple therapy. Five participants were EFT supervisors and one was a supervisor in training. Two participants identified as having a disability during the interview. Out of the 10 participants, 2 identified as men and 8 women. Nine participants identified as white and and one who requested to not have their race/ethnicity identified in the study. The range of ages of participants was 28 to 63 with a mean age of 46.3 and SD = 11 years. Participants ranged in their experience providing EFT, the range was from two years to 10+ years of providing EFT in couple therapy with a mean of 6.1 years (SD = 2.6). The majority of participants identified only serving one interabled couple while two having served more than five, with a mean of 2.9 (SD = 2.7) couples seen.

Table B.1

Participants

Pseudonym	Credentials	Years of EFT Experience
Kate	LMFT, Certified EFT Therapist	2 years
Cristina	LCSW, Certified EFT Therapist and Supervisor	6 years
Mimi	LCSW, LMFT, Certified EFT Therapist and Supervisor	10+ years
Dolly	LMFT, Certified EFT Therapist and Supervisor	10+ years
Love Worker	LCSW, Certified EFT Therapist and Supervisor	5 years
Rose	LMFT, Certified EFT Therapist and Supervisor	6 years

(table continues)

Pseudonym	Credentials	Years of EFT Experience
Caroline	Licensed Psychologist, Certified EFT Therapist	7 years
Jack	LMFT, Certified EFT Therapist	4 years
Sophia	LPC, NCC, Certified EFT Therapist and Supervisor in Training	7 years
Sasha	LCSW, MFT-C, Certified Therapist and Supervisor	4 years

Note. The participants selected their own pseudonyms at the conclusion of the interview.

Data Sources

Semi-Structured Interviews

Given the nature of IPA in exploring meaning making, one-time in-depth semi-structured interviews were utilized for data collection (Allan & Eatough, 2016; Larkin & Thompson, 2011; Roebuck & Reid, 2019; Smith et al., 2009; Smith, 2011). In conducting in-depth semi-structured interviews, I learned about the "lifeworld" of each participant as it relates to the phenomenon of serving interabled couples (Smith et al., 2009). An interview schedule was utilized with questions derived from the research question and topic of interest. Smith et al. (2009) recommended the interview schedule be between 6-10 questions with prompts. I developed an initial draft of questions with the goal of being open and expansive and focus on the "how" rather than "what" for the phenomenon (Smith et al., 2009). Prompts such as "tell me about that" were utilized for questions that are abstract and require more thought. Prompts were reviewed by an expert panel of 3 counseling faculty members and one marriage and family faculty member who have experience in qualitative methods. I piloted the initial draft with a volunteer counselor to identify questions needing to be edited or removed during the redrafting process (Smith et al., 2009). The interviews ranged from 35-70 minutes based on the participant. Only my auditor and I had access to the data.

Reflexive Journals

During the coding phase, I engaged in two types of reflexive journaling (i.e., personal and epistemological) (Allan & Eatough, 2016; Miller et al., 2018; Smith, 2011). Personal reflection bracketed my values, experiences, interests, and beliefs. Epistemological reflection bracketed the assumptions about the research, literature, and experience doing the data collection and analysis process (Allan & Eatough, 2016). The journal entries were stored electronically in a secure and HIPAA compliant platform with only the auditor and I having access.

Procedures

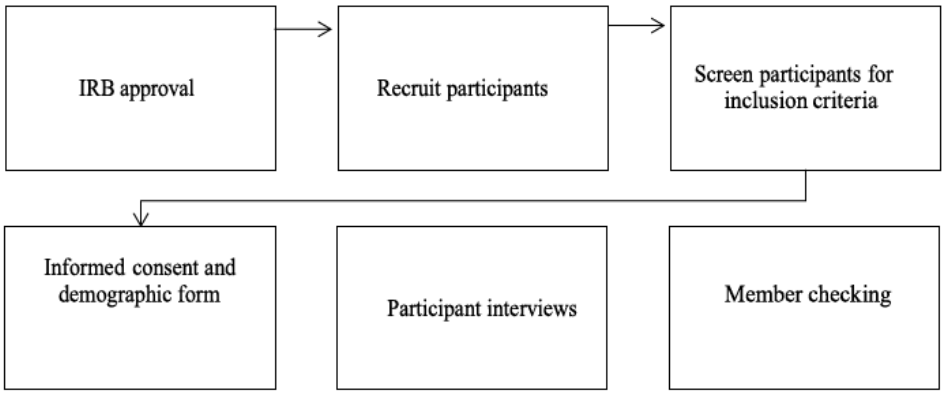
I obtained approval from the institutional review board (IRB) at my institution. The research team (i.e., principal researcher and auditor) completed research training specific to studying human subjects prior to engaging with the study. The research team met to discuss the purpose of the study and research question. I engaged in personal and epistemological reflection before completing any tasks (Smith, 2011). As a research team, we met to review the procedures for auditing process and discussed any questions during that time. Once reflections and initial meeting were completed, I piloted the interview schedule with a volunteer counselor to receive feedback in order to redraft questions (Miller et al., 2018; Smith et al., 2009). Once the interview schedule had been finalized, I began to recruit participants.

The participants were recruited using a typed script describing the study through email. The script outlined the research study, purpose, eligibility criteria to participate in the study and length of time involved. I searched for potential participants using the ICEEFT website in searching through the directory in the U.S. which resulted in over 2,000 names. The script was sent to the first 400 ICEEFT members throughout the US. Once I was contacted by a potential participant, a review of eligibility criteria was conducted for trustworthiness of sample (i.e.,

homogenous). A secure link was sent with the consent to participate along with a demographic questionnaire. Once signed, I scheduled a one-time virtual interview via a HIPAA compliant secure platform (i.e., Zoom).

Figure B.1

Procedures



Prior to the interview, I engaged in personal reflection about assumptions, biases, and thoughts (Smith et al. 2009) and upon completion of the interview (Allan & Eatough, 2016). I completed each interview using the finalized interview schedule that ranged between 35-70 minutes. Following the interview, I obtained a transcript of each interview using REV.com. Smith and colleagues recommend verbatim transcription be completed immediately following the interview. As transcripts were obtained, I provided these to the participants as a member checking mechanism. Member checking gave participants an opportunity to review the document for accuracy and provide any feedback (Stake, 1995). All participants provided the go ahead to move forward after having time to review their individual interview transcripts. After member checking was completed, the data analysis process began.

Positionality

The research team included a lead researcher and an auditor. As the lead researcher- I

identify as a non-disabled gay Latinx man. I am a doctoral candidate with 10 years' experience working with the disability community in professional and clinical positions in case management, state rehabilitation, private rehabilitation, and private practice. I hold a master's degree in rehabilitation counseling, and I am seeking a doctoral degree in counseling. I am a certified rehabilitation counselor, a licensed professional counselor, and a national certified counselor. I have clinical experience serving interabled couples in private rehabilitation. I have advanced training in EFT with both couples and families. I enter the research with assumptions of how a couple should function to experience strong relational attachment after one partner acquires a disability. Additionally, I have assumptions that interabled couples require specialized support in couple counseling. I am aware that I hold biases about sexuality and disability which will need to be explored through reflexivity to prevent misinterpretation of data.

My positionality may impact overall findings and interpretations as I do not identify as being in an interabled relationship and have no personal experiences with having a disability. I identify with multiple marginalized groups/identities and am in a same-gender marriage. I approach this specified population with having clinical experience working with interabled couples for over three years and PWD for 10 years. The clinical experiences derive from my work at a post-traumatic brain injury facility (i.e., TBI and stroke). I have three years of clinical experience working with interabled couples in various stages of rehabilitation and relationship dynamics. A few clinical cases have shaped my view of relational dynamics after a partner acquires a disability which I intend to explore. My collective experiences have created a desire to further examine the support available for interabled couples in couple counseling using EFT. Due to my clinical experiences, I assume that therapists with little training in disability work will not understand the needs of interabled couples. Having completed several EFT trainings, I

assume that the EFT therapist will not be confident in serving interabled couples due to the limited diverse examples in training videos and content.

The second member in the research team served as an auditor who holds a PhD in counseling and identifies as a non-disabled queer Afro-Latinx gender non-binary feminine presenting person, pronouns they/them/theirs/ella with experience using equine therapy to serve various types of clients. The auditor also has experience in qualitative research in participatory action research and photovoice.

The design of IPA research varies in the utilization of research teams. If research teams are utilized, Smith et al. recommends seeking support throughout the data collection and analysis process from co-researchers (Rizq & Target, 2008; Smith et al., 2009). The use of an auditor provided support in examining and evaluating internalized biases and held beliefs about people with disabilities and EFT throughout the research process. The use of an auditor assisted in deepening the analysis process in IPA as well as enhance trustworthiness.

Data Analysis

Smith et al. described the process of IPA as an "iterative and inductive cycle" (p. 79) that allows the researcher to conduct an immersive analysis for every participant to engage with the meaning making of the participant's experience and to understand their "lifeworld" (Miller et al., 2018) which aligns with the idiographic philosophy of IPA (Smith, 2011). In order to apply an interpretative lens, the lead researcher must self-reflect on any assumptions and biases before engaging with interpretation of data (Miller et al., 2018). Steps for analysis within IPA are not prescriptive as it allows for diverse perspectives to modify the approach to data analysis (Miller et al., 2018). Each participant's case was analyzed through a series of steps outlined by Smith et

al with modifications to include an auditor throughout. I completed the following six steps provided by Smith et al.

1. Reading and rereading: I sent each completed transcript to participants for member checking to review for accuracy before beginning the data analysis. I immersed myself in the one participant's case through the transcript and recorded interview. I went through the transcript with audio/video to grasp the essence of the participant's voice (i.e., lifeworld). I re-read the transcript with audio/video to further make sense of the participant's interview. I wrote down notes based on information that stood out during the re-reading process and recollections that were separate before engaging in the initial noting process. After the re-reading process with note-taking was completed, I engaged in self-reflection on the interview itself and noted any thoughts, assumptions, and biases.

2. Initial noting: I created a column along the transcript to write comments throughout the entire transcript. I utilized the three types of comment strategies recommended by Smith (2011). I first completed a round of descriptive (i.e., describing the content of what one participant shared) comments to engage with the data on a surface level focused on the content of the participants words. The second round of comments included linguistic (i.e., exploring the specific use of language) comment which focused on the use of language such as metaphors, phrases, and emotional statements. The third and final round of comments of conceptual comments (i.e., interrogative and conceptual) allowed a more interrogative process in meaning-making. I completed all three comment strategies before moving on to the next step.

3. Developing emergent themes: I created a third column within the transcript and began to explore interrelationships, connections, and patterns between the three types of comments. My

focus shifted from the entire transcript to parts of transcript and the initial notes (i.e., hermeneutic circle). Emergent themes were noted throughout each participant's case.

4. Searching for connections across emergent themes: Once emergent themes were identified. I developed a chart/map of the themes. The themes were then grouped based on similarities. After the themes were grouped based on similarities and connections, I utilized the technique of subsumption- "operates when an emergent theme itself acquires a super-ordinate status as it helps bring together a series of related themes" (Smith et al., 2009, pp. 97). Once super-ordinate themes were identified, I completed a chart/map of that one participant's case including the page and line number for each nested theme within super-ordinate themes and set it aside.

5. Moving to the next case: Once I completed the first participant's case, I submitted my analysis document, emergent themes document, super-ordinate theme table, notes taken for the case, and personal and epistemological reflection to the auditor for review. Before I moved on to the next case, I met with the auditor to have peer debriefing about the analysis process and findings for one case. Once the meeting was concluded, I engaged in reflection before moving onto the next participant. In moving on the next case, steps 1-4 were repeated for each participant's case. I bracketed my thoughts/feelings that emerged from each case before entering and immersing into another case. The auditor and I met upon 10% of the data being completed, 50% of the data being completed, and 100% of the data being completed. Each meeting involved reviewing all the documents reviewed by the auditor and peer debriefing. Changes and modifications were made based on the recommendations of the auditor.

6. Looking for patterns across cases; After 50% of participant's chart/map had been completed, the auditor completed an independent analysis of five participant cases to provide

credibility checks. Once credibility checks were completed for 50% and 100% of participant data, I examined all super-ordinate charts/maps for connections, patterns, and differences. I reconfigured and relabeled themes based on connections and patterns. The IPA quality evaluation was utilized to identify appropriate recurrence in themes based on sample size. Extracts from half of the participants for each theme in addition to prevalence of themes are provided in the final table.

The findings were organized in a master table that include extracts from half of participants for each theme based on having a large sample size (Smith et al., 2009). In addition to the master table a measure of prevalence across themes was developed (See Table 4). At the conclusion of analyzing all participants, an extensive audit trail was provided to the auditor for review.

Trustworthiness

To increase credibility and trustworthiness in an IPA study, I utilized several validation strategies and techniques. I used the following: audit trail, member checks (Birt et al., 2016), reflexivity (i.e., personal and epistemological; Smith et al., 2009), quality checks (Dickson et al., 2011), and the use of IPA quality evaluation guide (Miller et al., 2018; Smith, 2011) to increase trustworthiness.

To ensure quality and rigor for trustworthiness, Smith (2011) developed the IPA Quality Evaluation Guide to establish standards for good, acceptable, and unacceptable research. I utilized the evaluation guide to enhance trustworthiness based on sample size (see Table 3). For example, for sample sizes greater than 8, extracts from at half of participants for each theme in addition to measure of prevalence of themes are recommended (Smith, 2011, pp. 17).

Table B.2

IPA Quality Evaluation Guide

Quality	Description
Good	Paper must clearly meet all criteria for acceptable, plus three additional: Well focused; offering an in-depth analysis of a specific topic; Data and interpretation are strong; and Reader is engaged and finds it particularly enlightening.
Acceptable	Clearly subscribes to the theoretical principles of IPA. Sufficiently transparent so reader can see what was done. Coherent, plausible and interesting analysis. Sufficient sampling from corpus to show density of evidence for each theme: N=1-3: Extracts from every participant for each theme; N=4-8: Extracts from at least three participants for each theme; and N>8: Extracts from at least three participants for each theme + measure of prevalence of themes, or extracts from half the sample for each theme.
Unacceptable	Does not meet the four criteria for acceptable: Not consistent with theoretical principles of IPA; Insufficiently transparent for reader to see what was done; and Poorly evidenced.

Note. Adapted from Smith (2011), p. 17.

APPENDIX C

UNABRIDGED RESULTS

As outlined in Appendix B, I utilized the recommended steps for data analysis in Smith et al. (2012). The IPA analysis process requires an in-depth examination of the data which resulted in multiple nested themes within the super-ordinate themes (Smith et al., 2012). After each participant's case was completed with its own super-ordinate themes table, I laid out all 10 results tables (one per participant) and began reviewing each one with detail. While the analysis was comprised of six steps, the final step in analysis centered around using all 10 participants' results tables to examine similarities and commonalities across cases. Table 4 presents the super-ordinate themes, nested themes within the super-ordinate themes, and the prevalence among all 10 participants. Each super-ordinate theme and nested themes represent findings in at least 50% of sample (Smith, 2011).

I identified four super-ordinate themes that emerged from the data including (a) ableism, (b) self-of-the-therapist, (c) relationship dynamics of interabled couples, and (d) the "fit" of EFT approach with interabled couples. I describe each super-ordinate theme, nested theme, and report prevalence by illustrating quotes from 50% of participant sample. The following are the results including each super-ordinate theme and nested themes.

	Kate	Cristina	Mimi	Dolly	Love Worker	Rose	Caroline	Jack	Sophia	Sasha
Ableism		X		X	X	X	X	X	X	
Self-of-the-therapist	X	X	X	X	X	X	X	X	X	X
Heightened self-awareness	X	X	X	X	X	X	X	X	X	X
Therapist insecurities	X	X			X	X	X	X	X	
Impact on therapist's behavior	X	X		X	X	X	X	X	X	X
Emotional impact on therapist		X		X	X	X		X		X
Relationship Dynamics of Interabled Couples	X	X	X	X	X	X	X	X	X	X
Disabled client's experience	X	X	X			X	X	X	X	
Non-disabled partner's experience		X		X				X	X	X
Interabled relationship dynamics	X	X	X		X	X	X	X	X	X
Therapists' conceptualization of interabled couples in therapy	X	X	X		X		X		X	X
The "Fit" of EFT Approach With Interabled Couples	X	X	X	X	X	X	X	X	X	X
Strengths of EFT			X	X	X	X	X	X	X	X
Limitations of EFT	X		X	X	X			X		X
Disability-responsive adaptations	X	X		X	X	X	X	X	X	X
Future recommendations			X	X	X			X	X	X

Super-Ordinate Theme 1: Ableism

Throughout the interview process, participants shared their various experiences of serving interabled couples in couple therapy. For many of the participants, their perceptions of people with disabilities were described with deficit-oriented language. Ableism includes negative, deficit-oriented views of disability shaped by the history of treatment towards people with disabilities, societal messages of "otherness," and cultural understandings which informs one's own understanding of disability (Nario-Redmond, 2020).

Many participants described their experiences through deficit-oriented language around their clients with disabilities. This language included seeing disability as "permanently damaged," "physically challenged," "struggle," "a darkness," and "affliction." Seven participants utilized deficit language in describing their lived experiences serving interabled couples. Different participants expressed various overt and covert messages of ableism.

Rose's comments around disability demonstrated the use of deficit-oriented language. That is, even in discussing the word "disability," Rose became visually uncomfortable and stated "I really, really hate the word disabled. I always do my best not to use it. I prefer to use relative able ability instead of disability because disability is a very belittling word." For Rose, the word "disability" itself was, in essence, deficit-language.

Related to this, Sophia spoke about an interabled couple she worked with, explicitly discussing one client's disability. More specifically, she described the way in which her client acquired their disability through a car accident along with the subsequent impact on their relationship in this way "they really went through a lot together just in her recovery, but her body is permanently damaged in a way that doctors can't find a way to repair."

Alternatively, a few participants shared their experiences while being cognizant of

ableism and naming disability as a social construct during the interview. For example, Love Worker described a disabled client using both deficit-oriented language and disability-responsive language by stating:

> Again, sort of mindful of what might be happening for them. Curious, do they have any kind of anxiety or embarrassment? And also, again, just wanting to sort of give them space in some kind of respect and dignity that I would hope to give anybody that comes into my room.

In Love Worker's response, he mentions the potential embarrassment of a client sharing their experience with a disability while also wanting to make space to demonstrate respect. Love Worker shared his curiosity of how the disability might show up in their relationship.

This hesitation or difficulty in raising the topic of disability was shared across participants. For example, Jack shared the difficulty of acknowledged disability in couple therapy with interabled couples by stating:

> And it takes a courage, even for a therapist, it takes a courage to bring it up, to discuss it, to talk about it, to stay with it, understand the emotions. Because we don't want to upset our clients. We don't want them to feel bad. We don't want them to feel terrible.

Here, Jack explained his perspective on the characteristics a therapist must possess in order to name disability in the room. From his view, it takes courage to explicitly acknowledge disability when working with interabled couples. Moreover, he explained the importance of finding and maintaining a balance of not evading disability while also not wanting to upset the clients.

In addition to ways in which participants explained how they navigated disability conversations in the room, they also indicated that their experiences serving disabled clients were inherently different. For example, Dolly explained that the experience of serving interabled couples was different than other couples she had worked with. She stated:

> You know that you're not going to reach the same [paused]. I think it's even different than couples with trauma because I've worked with a lot of couples and, in a way, you could think of that as a deficit. It feels different to me.

Dolly used the word “deficit” to describe the differences in serving interabled couples.

Super-Ordinate Theme 2: Self-of-The-Therapist

Also prevalent in the data was the theme of self-of-the-therapist. This included awareness of one’s inner process, knowing oneself, and unexplored parts of self that impact client and therapist. The self-of-the-therapist super-ordinate theme was identified in all 10 participants, each highlighting various aspects of self and their work with interabled couples. The four nested themes discussed are (a) therapist insecurities, (b) impact on therapist’s behavior; (c) emotional impact on therapist, and (d) heightened self-awareness.

All ten participants emphasized their own insecurities in serving interabled couples. For many participants, these insecurities often resulted in an increase in self-awareness. Before participants could reach this heightened awareness, they first discussed their insecurities that surfaced in their work with interabled couples and the impact that serving interabled couples had on them.

Therapist Insecurities

This theme encompasses the ways therapists’ insecurities show up in clinical work and the various methods therapists deployed to navigate the discomfort. For example, Caroline and Cristina both shared similar experiences in their initial contact with their interabled couples and the fear and anxiety that they experienced by stating:

> Part of the fear is like, can I find a way into their space? Can I see what’s happening? Can I come alongside them in a way that feels meaningful? Can I build the alliance that helps them feel safe, so they can take the risks, so they can do this work? And then if they have anything else extra in terms of layers like disabilities, will I be able to understand enough of what they’re experiencing so that I can accommodate in a way that feels honoring to them, meets their needs? [Caroline]

> I definitely felt it from the start when they kind of shared they were wanting to do couples work, and this is what they’re needing. I felt kind of my worry of, is this going to

> work for them? Is this… just physically tangibly, is this going to be an okay fit? Yeah. [looks away] That's feels hard to even say, I guess, because it was more hesitant of, am I going to be able to offer them what they need? [Cristina]

Both Caroline and Cristina expressed great concern in wanting to serve them properly and worried about their own capabilities to serve interabled couples. This experience was common across participants in describing the initial fears with serving interabled couples.

During the therapy process, some participants mentioned the difficulties they experienced in navigating fear in the moment. For example, Rose shared her fear of serving an interabled couple where one partner had a severe speech impairment. She stated:

> Most challenging was walking on eggshell. I didn't want to hurt their feelings. I didn't want to be inconsiderate in any way, but with other couples, I could give some permission to myself. I'm not from this culture, I'm learning, but it was not... I didn't permit myself to do that with this couple and maybe that should change.

Rose experienced difficulty in being able to ask the disabled client to repeat themselves in session. Additionally, because English is not her first language, she shared that it added a layer of anxiety in prompting the interabled couple as she would with other clients who are non-disabled couples.

Aside from "walking on eggshells," one participant expressed the difficulty of discussing an interabled couple's sexual needs. Sophia mentioned the moment she was challenged in serving an interabled couple, she stated:

> I think for me… it was the first time I ever even had a couple talk about how their sexual life was impacted. I'm not a trained sex therapist… When they said, "Can you talk with us a little bit about sex and marriage when there's disability?" That was the challenging part.

Sophia highlights the needs her interabled couple had regarding their exploration of sex within couple therapy. She expressed the challenge in navigating those conversations in session with the couple because she was insecure in her own capabilities. She continued to share that her focus

remained on the emotion and did not explicitly cover discussions around sex.

Love Worker highlighted the extra work involved in finding a balance as he discussed the need to be mindful while also not further oppressing clients with disabilities by stating:

> I would like to say, I'm mindful when I'm aware of someone having a disability of wanting to provide openness for any kind of accommodation that is requested or seems to be needed. But I also want to be very aware of not treating people with disabilities in a patronizing or paternalistic way.

Love Worker described not wanting to patronize or paternalize clients with disabilities which impacted his decision-making. Throughout the participants' expressions, therapists experienced varying levels of insecurities in serving interabled couples.

Impact on Therapist's Behavior

Impact on therapist's behavior encompasses experiences of therapists serving interabled couples and the therapists' mental barriers that showed up in their work. As part of self-of-the-therapist, understanding one's own internal process helped ensure the therapeutic process was not greatly impacted by negative views of clients' identities. For example, Sasha shared her experience in navigating how she explores the client's disability within couple therapy. She stated:

> So maybe a word to say would be tentative around just really wanting to get it right and wanting to not be like, 'Oh, I don't see your disability." [moving hand over face] Right? But also not be invasive or overly focused on, "All I can see is that you don't have the rest of your arm and that we should talk about that again. Let's talk about that again."

Sasha shared the difficulty of discussing the disability while also not overly focusing on it during therapy. She explains the desire to get it "right" and not evade the topic of disability but not having it take too much space in session.

Feeling tentative is similar to what Cristina experienced, her feeling of not knowing what to do in session evoked discomfort for her. She stated:

> I was surprised that I was initially had that hesitance and a little bit of the discomfort. I didn't feel good to have it, and so I think it was like a learning experience of like, wow, this is uncomfortable for me. I feel very awkward. And I don't exactly know what to say or what to do or not do or how to make it clear that like I'm here and I'm with you in this process.

Cristina emphasized the awkwardness in feeling discomfort of not knowing what to do in serving her interabled couple. She shared being surprised by her emotions and reaction of being faced with needing to serve an interabled couple.

Cristina's reaction is echoed by Dolly's sense of sadness in the outcomes for her interabled couple. She stated:

> It just felt so sad, like a deeper sadness and I think it's because the same hope that you have with a couple that doesn't have this other thing like a disability. [long pause] You always have this hope of what's possible. And it's not the same, if that makes sense.

Dolly's hope for couples in couple therapy is different for interabled couples. She described a deeper sadness in the outcomes of the relationship.

In Rose's experience with her interabled couple, she described the impact of her client's disability keeping her from clarifying the client's statements. She stated, "I didn't want to pause and repeat. 'Hey, I can't understand it. Can you repeat that?' It was torture for me. So, a lot of times, I let go of things without understanding." She shared there were moments she would not clarify statements and move on as if she understood what was said. She expressed that her decision to move on at times was due to her feeling tortured by asking the client to constantly repeat themselves. An additional layer to this experience, she shared that because English is not her first language, it became an additional barrier in their work.

Lastly, Kate described a difficult experience in validating her interabled couples experience. She stated:

> I also don't want to use his disability as a way for me to just say like, 'Well, I can't listen to you, because you have a TBI.' Which seemed like what she was wanting me to be able

> to do just to get a better sense of her reality... It's just a hard balance in terms of validating the experience of the couple, but also not wanting [disability] to rule the show.

Kate described the struggle in balancing the experiences of the interabled couple she served. She identified how hard it was to validate both partners without overt focus on the disability in therapy.

Emotional Impact on Therapist

In addition to the therapist's behavior being impacted serving interabled couples, participants described the long-term impact on them as therapists. The impact each therapist experienced serving interabled couples varied, seemingly based on their own knowledge of disability. For example, Cristina openly shared the difficulty in life being unfair to interabled couples. She stated:

> I think…… this is really hard. It's really not fair and it's hard, and a little bit of like, there's nothing to be done with that. I don't know. There's so many ways in our world, in this country in particular, which we'd want to fix or do. We think we can overcome anything and everything, and we always have a plan for something. And like you can't [smiles]. And that's just painful and hard.

Cristina reflected on her experience and felt the weight of aspects of the interabled couple's life not changing, specifically the disability. She mentioned the pain and difficulty of not being able to change the disability for the interabled couple.

Similarly, Rose spoke about the emotional impact working with one particular interabled couple. Rose discussed the systemic barriers this couple experienced with obtaining needed services for independent living. She stated:

> If that happens to a person with disability, I can't go to sleep. It's different…I just wanted to cry my eyes off and understand why the government doesn't send somebody every day to them to help to shower the kid. They couldn't do it. They physically couldn't do it.

She emphasized the difficulty the interabled couple experienced in raising a newborn and the limited resources available for them.

For some participants, it was a sense of grief that was experienced in their descriptions of working with interabled couples. For example, Dolly shared the impact of serving one interabled couple. She stated:

> I was new to the tragedy and I just wept after they left. I was just so heartbroken for them that she had it during childbirth. So, she had these children, they lost a mom, her husband lost a wife. She lost herself as she was still there, but not really there.

Dolly emphasized the impact of disability on the family and being heartbroken in experiencing that with them in couple therapy.

Although not related to serving an interabled couple, Sasha shared a personal experience with a friend acquiring a disability that has left an impact on her and how she conducts therapy with disabled clients. She shared:

> I have a good friend who was paralyzed about seven years ago…I was very intimately involved in her journey from being physically able to being disabled. And so, I think that has shifted my perspective on working with folks with disability.

The personal experience Sasha had directly shifted her perspective of people with disabilities. The shift of perspective provided support in serving interabled couples according to Sasha.

For one participant, shifts in perspective were difficult. Jack shared the frustration felt serving an interabled couple. The difference for Jack was being able to acknowledge the frustration impacting therapy. He stated:

> For me, it was a little bit frustrating, a little bit difficult, but I also knew that I needed to get my own help and I reached out for additional support from colleagues to help me just to make sense out of it.

For some participants, examining their experience of serving interabled couples brought additional awareness that was explored through various methods, reflection, supervision, and therapy.

Heightened Self-Awareness

As participants shared their insecurities and the emotional impact serving interabled couples, the discussion evolved to many expressing a heightened awareness of self. This self-awareness involved understanding themselves more and identifying ways to support interabled couples. For one participant, serving interabled couples expanded their understanding of emotion. Caroline stated:

> I don't know, it just expands my understanding of the possibilities of pain in this world, the range, the variety, the flavor, the color, how it can impact somebody… How much is the physical stuff underneath it? But what meaning lands on the other partner. And had them processing that meaning so that they can get clear signals.

Caroline described the expansiveness in emotion, specifically pain. She described pain with various layers of complexity.

For one participant, personally navigating having a disability (hard-of-hearing) evoked heightened awareness in her work with disabled clients and specifically interabled couples. Dolly stated:

> I was like, what are you talking about? I'm good. That's how I coped. And so part of my growth and my own healing has been to get in touch with that part of myself that can't hear. There's this huge, there's just so much to that… I think even though I'm much more comfortable with it now and open about it and talk about it and all of that, I don't like thinking, it still, it's like, Oh, don't say that's not, I don't have a disability, but I do. You know what I mean?

During the interview, Dolly openly spoke about her disability and its connection to her work. She shared continuing to work on accepting that piece of herself.

For other non-disabled participants, the impact of serving interabled couples was an increase in attunement in their work. For instance, Cristina stated:

> It really affected me as I go through my life and all the things, I take for granted and all the things that are challenging for them and others who have disabilities. It really made me a lot more attuned and empathic.

Cristina described two processes occurring. First, she realized the differences in her own experiences as compared to her clients with disabilities. Secondly, she shared becoming more attuned and empathic as a result of serving interabled couples. Similarly, Mimi, expressed her level of awareness that she experienced serving interabled couples. Mimi stated:

> Both my own awareness of having to show up in a little bit different way, do things a little bit differently… I want to be really aware of my experience that's different and making sure that I'm not saying or doing something that could be hurtful or harmful. And I think that I…I mean, I think with everyone, I try to make it really clear that I want to get feedback.

Given the various experiences of participants in serving interabled couples, Mimi highlighted the need to show up a little different for interabled couples. She also opened the door to have feedback from clients be part of her therapeutic process.

Another experience shared by a few participants was an acknowledgement of non-visible disabilities through experiences with interabled couples. Sasha explained:

> I think it's probably increased my awareness of invisible disability for one, and also helps to just undo what I think can be a reflexive belief about like, "Oh my gosh, that must be so different." Kind of, right? To recognize that there are important differences and also interabled couples struggle with many of the exacts, the same things that couples where both folks identify as able, right?

Through serving interabled couples, Sasha increased her awareness of non-visible disabilities being a part of couples' experience. All participants experienced insecurities in serving interabled couples and many described similar experiences in how they responded to those experiences.

Super-Ordinate Theme 3: Relationship Dynamics of Interabled Couples

This super-ordinate theme of relationship dynamics of interabled couples includes the meaning made by the therapists' work with each partner in the interabled couple, dynamics of interabled couples in couple therapy, and therapists' conceptualization of interabled couples'

relationship. Each nested theme presents the ways participants described different aspects interabled relationships observed in couple therapy. The four nested themes identified are (a) disabled client's experience, (b) non-disabled partner experience, (c) interabled relationship dynamics, and (d) therapists' conceptualization of interabled couples.

Disabled Client's Experience

Many participants shared different experiences working with each partner within an interabled couple. They all highlighted the differences that exist between the disabled partner and non-disabled partner and spent time sharing the meaning they made of the client with a disability. For the client with a disability, many participants shared the internal pieces of self that emerged in therapy. For example, Mimi discusses the view-of-self piece for clients with disabilities that were necessary to explore in couple therapy. She stated, "We're talking about these really vulnerable view-of-self kinds of things when we do EFT… a lot of times, negative view-of-self that's connected to that disability." Mimi expressed a big part of EFT is looking at view-of-self pieces in therapy which for the partner with the disability was connected to the disability.

Jack also shared the attachment fears of his client with a disability. He stated:

> They have heightened fear of being abandoned and dismissed. So that creates a special challenge… [partner with disability needing to hear] you're good just the way you are… because the partner who is disabled has a very hard time accepting that they are loved just the way they are.

The importance of hearing "you're good just the way you are" is emphasized by Jack as being an important message the partner with a disability needed to hear from their non-disabled partner. The weight of the words "you're good just the way you are" is echoed by Caroline. In sharing, she stated questions that surfaced for her client with a disability during her work with an interabled couple. She stated:

> The physical challenges would hit the core attachment fears of like…am I the person, the one person who is physically challenged? Am I pulling my weight? Am I working hard enough? Am I doing what will make you want to keep me?" She shared these questions that show the fear the partner with a disability experienced. "Am I doing what will make you want to keep me?

She emphasized the concern of the partner and worry about the relationship.

Differences in experience were reported in the ways clients with disabilities coped with acquiring a disability. For example, Cristina shared her client's process of dealing with the changes by closing off his emotions. She explained:

> Like for the husband [with disability] in this couple, again, part of his strength was to be able to kind of just keep going and therefore keep that door closed to some of the emotional stuff…what she [wife] was really needing, which is classic EFT, was for him to really understand, for her to be able to talk with him about her struggle, which inevitably evoked some struggle for him, a feeling of shame of, "My wife wouldn't be feeling this way if I weren't in a wheelchair."

While the coping strategy for the client was identified as a strength, Cristina highlighted the emotional impact around feelings of shame with the physical changes experienced by the partner with a disability. Similarly, Kate shared the frustration her client with a disability felt due to cognitive issues around memory. She stated:

> Partner [with disability] would just get defensive and say, "No, this is not it.' And other times he would say, "Okay, yeah, maybe you're right. Maybe I am remembering it incorrectly…" His memory would get distorted, and he would get more frustrated at himself.

Kate described the confusion and frustration her client felt about his memory during couple therapy. Many participants expressed their clients' emotions ranged from shame, frustration, sadness, and worry. These emotions were not unique for the partners with disabilities, similarities were highlighted in therapists' descriptions of the non-disabled partners.

Non-Disabled Partner's Experience

Many participants shared experiences of non-disabled partners in couple therapy and the

various roles they may carry within their interabled relationship. Dolly mentioned the role the non-disabled partner played during therapy, often stepping in to assist Dolly with statements made by the partner with a disability. She explained: “Depending on the dynamics that were different with each couple, but the partner that did not have the disability was used to being a translator, or just the one that was like the helping partner.” Dolly expressed the difficulty in balancing the role of the non-disabled partner in session to ensure the therapeutic process was not greatly impacted.

Cristina shared an experience with an interabled couple in which she saw the non-disabled partner individually more often outside of their scheduled couple therapy. She stated: “I did end up meeting with her because I think it was really hard for her to talk about her pain related to the disability, the accident, the disability in front of him.” Cristina noticed additional needs of the non-disabled partner which resulted in individual sessions to explore the pain related to the accident that impacted the partner with disability.

Sasha experienced a difficult situation with an interabled couple in which the disability was not visible. She explained that the non-disabled partner said to her: “How do you build empathy for something that you can’t always see?” Sasha described the difficulty for the non-disabled partner in navigating couple therapy when the impact of the disability was not always visible.

In identifying ways to support the non-disabled partner outside of couple therapy, Jack shared his experience with the non-disabled partner. He stated:

> The goal of the therapy was for him [non-disabled partner] to be able to accept who she [partner with disability] is and have that love that he had for her all these years to continue… he would go to the support group, because under the same organization there were support groups for couples, for the spouses of a disabled person.

Jack described the need for the non-disabled partner in couple therapy to work towards accepting

their partner with a disability and the support outside of therapy that was needed.

Lastly, depending on the limitations of the disability, the level of needs from the non-disabled partner may be greater. For example, Sophia said of the non-disabled partner's experience: "But after a few years he was exhausted, because he took over all the nursing care for her plus his own job." Sophia described the impact of the non-disabled partner serving as a caregiver for a few years which resulted in exhaustion.

Interabled Relationship Dynamics

Within the interabled relationship dynamics theme, participants shared their perceptions of unique differences serving interabled couples compared to non-disabled couples. Differences in relationship dynamics for interabled couples were noted in all participants. Specifically, the differences in equality between interabled couples and the various shifts to coupledom.

Sophia emphasized the differences in experience for interabled couples when she stated: "Financial burdens, emotional burdens, physical burdens. Overall, it's very complicated. There's extreme grief and loss." The compilations for some interabled couples in balancing their financial and relationship changes experience extreme grief and loss.

Complications in interabled relationships was further clarified by Cristina's experience with one interabled couple. She described the difficulties an interabled couple faced when attempting to purchase a home. She explained:

> They were trying to buy a house and need to have it retrofitted to the needs for his chair and wanted him to be able to drive and would get equipment… it didn't work. The level of daily stuff just sucked. [laughs and smiles] It was just rough.

The difficulties of finding accessible homes and equipment that works for the interabled couple became a source of frustration for them in therapy according to Cristina. She added that the daily level of stress was rough and difficult to navigate.

In addition to the changes to finances and need for access, participants described the level of inequality within interabled couples. For example, Mimi described the differences that exist between partners in interabled relationships. She stated:

> They obviously know about it, but you can't completely experience it in the way that your partner does. Depending on the disability, it can be more evident than others, right? So, that could impact the level of inequality there.

Mimi shared that while the couple may experience similarities to the changes in relationship, each partner will have different types of experiences. More specifically, she named the impact of inequality that exists for some interabled couples. One particular participant highlighted the type of inequality that can exist in interabled couples. Kate described the challenges interabled couples face depending on the type of disability. She explained: "'Well, you're not remembering that correctly.'" And then he would get frustrated and shut down, and so we would talk about it more in terms of what it was like for him when his disability either was a gap in connection for this couple… "Well, we can't trust him because he has TBI.'" Kate continued to state that the disability was a part of the relationship dynamic and creating moments of mistrust between non-disabled partner and the partner with the disability.

Rose explained that interabled couples have additional challenges besides their relationship distress. She stated:

> In addition to the difficult level of couple distress, they're also fighting in many other ends for their basic rights… In addition to negative cycle, they have to fight for very, very simple thing. It's a big, big challenge for them.

Rose witnessed the additional aspects interabled couples need to navigate while dealing with their relationship. She shared the fight for basic rights that often becomes a challenge for interabled couples.

Therapists' Conceptualization of Interabled Couples

Many participants worked to conceptualize interabled couples' experiences and shared their understanding within EFT. For example, Cristina shared factors she considered in conceptualizing the interabled couple. She stated:

> And they were coming to me a couple of years after that period when things were starting to get harder. Some of it was just unprocessed trauma that they experienced together…Yeah. Just kind of in those pieces that I'm saying in terms of ... I mean, [long pause] I think you might need to really understand the impact of the role changes for couples when a disability happens in the context of their relationship. So, like there are kind of acute things that I think still fit with EFT, but just it might be like additional things to be aware of as you put it into the EFT process and cycle.

Cristina expressed the importance of considering the disability as part of the relationship and applying to the EFT process. Another participant emphasized the importance of considering disability as an important factor in couple therapy.

Mimi identified disability as a contextual factor that helped inform her work. She stated: "I think if it was not something that I was thinking about as a contextual factor [disability], I think that I probably would have missed a lot of pieces around just that view-of-self part." She shared the need to not ignore disability as a factor in her work as pieces around view-of-self for the client with a disability would have been missed or ignored.

Furthermore, Caroline shared the importance of remember the duality of interabled relationships. She stated:

> There's so much more than whatever their physical challenges. They're coming in because of their heart and their bond is in distress…there are unique components that couples who have, our interabled couples have to navigate, to talk about, to name with each other, to be open in their hearts to hearing the emotions underneath and things like that.

Caroline shared the importance of understanding that interabled couples are coming because their heart and bond are in distress. The compounding factors may contribute which she further

continued by stating the need to name their hurt and pain and be open to vulnerability.

Alternatively, Sasha discussed the importance of acknowledging the disability as a potential influence in interabled couples' dynamics. She stated:

> That is just EFT, but naming explicitly that this is part of a disability, right? It's not a stubbornness, it's not an unwillingness, it's not any of these things that feel less like yeah, that are less interpersonally, welcoming, or easier, harder to soften towards.

Sasha explained the complexity of incorporating the disability as a factor in the interabled couples' distress instead of it being something more interpersonally.

Finally, Love Worker shared his conceptualization of differences in interabled couples compared to non-disabled couples. He stated:

> And I think those couples where they're different [interabled couples] is I think they have something that puts that [disability] all right in front of them more clearly, and perhaps more quickly than other couples who it's has to be sorted through before it becomes clear how they help each other.

He explained that interabled couples face dealing with their dynamics upfront much quicker than non-disabled couples dealing with distress. All participants discussed their conceptualization of interabled couples through an EFT lens.

Super-Ordinate Theme 4: The "Fit" of EFT Approach with Interabled Couples

Finally, many participants discussed the strengths and limitations of EFT and its application to serving interabled couples. All participants provided guidance and recommendations for ways EFT can support their work in serving interabled couples. The final super-ordinate theme presented contains four nested themes: (a) strengths of EFT; (b) limitations of EFT; (c) disability-responsive adaptations; and (d) future recommendations.

Strengths of EFT

Participants shared their experiences engaged with the EFT approach and its impact on clients they have served over the years. For Sophia, EFT fits all couple situations that present themselves in couple therapy. She stated:

> I think EFT is really the perfect fit for any type of situation, because couple work is about connection, helping people reconnect, and helping them recognize negative patterns that are causing them to disconnect. I love EFT, because you make the enemy the negative cycle. You help them learn that each other doesn't have to be your enemy. They can actually be your very best supportive partner in this struggle. Just helping people get that new perspective, EFT fits with, I think, any type of couple situation. [laughs]

She expressed her love for EFT and the tools it has given her in being able to externalize the problem as the negative cycle. Sophia strongly believed EFT fit any couple's situation and provide healing and help to reconnect.

Another strength mentioned was by Caroline, she expressed the importance of the EFT roadmap provided by Sue Johnson. She explained:

> So that's sort of the part of the courage comes in with fear that we have this lovely roadmap that Sue Johnson has given us. So, we take the map in, and we take our authentic selves in, and yes, we can be scared going in, but we just meet and find the real person and we just come alongside. [hands in the air]

Caroline expressed being able to be her authentic self within EFT and walk alongside her couples to find the real person.

Given the previous mentions of inequality within interabled couples, Jack shared the power EFT holds as an equalizer. He stated:

> But EFT, it has that unique ability to equalize the playing field. I usually, when I work with couples like this…working with couples, whether they're young, old, disabled, or not, the conceptualization is very similar across the population because John Bowlby said we need to be attached to another person from the cradle to the grave.

Jack highlighted the ability to equalize the therapeutic space with interabled couples within EFT. He also mentioned the power of attachment within EFT through John Bowlby's work.

Additionally, Sasha shared the importance of EFT training in providing an understanding of how to name things and be curious. She stated:

> I think I just go back to my training around being curious, not being afraid to name things. So I go back to my training around make the implicit explicit. I'm not in an expert position, I'm just staying curious, right? I focus on the skills I always use of like checking-in, right?

Key tenets of EFT were mentioned by Sasha in making the implicit explicit and remaining in a curious position in working with couples. This was mentioned again by Mimi, she shared the many ways EFT practices are done with interabled couples. She stated:

> I think it's just such an EFT thing. There's something so rewarding about being able to see people connect in this deep way and being able to see people reach to their partner from such a vulnerable place and have their partner respond to them in such a loving, accepting way… That's how I see the world. But I think that attachment is so strength-based. I think that EFT is so strength-based.

Mimi identified a major strength in EFT being that it is strength-based. She continued to express how rewarding it is to see couples connect in a different way through EFT.

Limitations of EFT

While EFT has many strengths in serving couples in couple therapy, most participants identified limitations in serving interabled couples. These limitations varied based on the type of disability and interabled couple's needs. Participants shared their challenges in providing standard EFT.

For example, Kate shared the difficulties in making modifications. She stated: "I think the most challenging part for me was just modifying EFT in a way that didn't feel dismissive or invalidating of her [partner with disability]." She expressed the difficulty in not being dismissive in modifications that considered the partner with the disability's needs. Similarly, Dolly expressed being limited in serving the client with a disability using standard EFT. She stated:

> Yeah, I felt very limited, felt like, I think something that was hard is I felt like, am I actually helping them. Again, didn't necessarily feel like I could do the same kind of EFT that I was used to doing that I had confidence in.

Dolly shared feeling limited in applying the same EFT with her interabled couple. She also expressed not feeling as confident in herself. Jack expressed being confronted with a similar dilemma of standard EFT not applying to his interabled couple. He shared:

> I said to myself, "Well, I'll be there. I'll help them to navigate through this." But it became very difficult because nothing standard would apply. Because she [partner with disability] couldn't move, she couldn't do things.

Jack shared the limited mobility the partner with a disability had to turn to her partner during therapy.

Many of these challenges mentioned by participants are reflected in the discussion around interabled couples and training. Sasha mentioned the lack of discussion around interabled couples in EFT trainings. She stated:

> Yeah. I don't think that there has been a whole lot of explicit mention in any trainings that I've done…I do think any training I've done that has named working with marginalized identity has been helpful, but I've had to run it through another frame of like, "Okay. I've talked about this related to race for example, but how would I do it with interabled?"

Sasha highlighted the gaps in discussion around interabled couples in training compared to the discussions around race. That point is further echoed by Mimi, she shared the multiple times she has brought in conversations and broached differences. She stated:

> I feel like there's been more talking about what it's like to talk with or work with a couple who is of a different race than you or what it's like for me as a straight person to work with a gay or lesbian couple or even an interracial couple [smiles], but ability, disability, that one just doesn't seem like it's talked about a whole lot.

Mimi explained her exposure to discussions around serving various couples with different identities but no mention of ability and disability. While the limitations were described

by most participants, many found themselves working to find meaningful ways to adapt their work to best serve interabled couples.

Disability-Responsive Adaptations

Considering the participants' observed limitations of EFT, nine participants described disability-responsive adaptations they made when working with interabled couples. The majority of participants shared various methods they attempted to adapt their standard EFT process to meet the needs of clients with disabilities.

In examining the work therapists do upon scheduling a client, Cristina shared her experience of answering the interabled couples' initial questions. She stated:

> I had some hesitance honestly, in kind of figuring out, is that going to work? And so, I kind of explained what my office is like and what I would be able to do. I did need to make some adjustments, but small adjustments in terms of chairs and things… I took the measurements of my office. They said that would work. We said, "Let's give it a try. Let's see how it goes."

Cristina shared taking steps to ensure she would be able to serve the interabled couple. She identified a few important steps of measuring office space and also making furniture re-arrangements.

Another participant shared the importance of having additional information about the disability at the start of couple therapy. Kate shared: "Then the partner with the traumatic brain injury brought in his medical history for me when I first met him, so I could get a better sense of where he was coming from, which was helpful."

Kate discussed the benefits of obtaining the medical history of the partner with a disability at the start of couple's work.

In providing support to interabled couples during couple therapy. Caroline mentioned the changes made in therapy at different times to support the partner with the disability. She shared:

> In actual therapy sessions, sometimes we had to make physical rearrangements in the room, because of the physical challenges. So, sometimes providing extra pillows, so an arm is propped up, or putting an extra little table.

Caroline expressed the utility of making physical rearrangements to prevent the client with a disability from feeling pain during sessions. She highlighted the importance of working to keep the interabled couples focused on the therapeutic process.

Providing support and rearrangements supports immediate needs of interabled couples, but the therapist at times needs to be aware of the disability which Love Worker mentioned by stating:

> I think it would need to be, one thing that would probably be true is to name interability as a phenomenon…so that if trainees have any kind of questions or discomfort [around disability], or they don't know what to do, they [disability topic] can be brought into the room in trainings or in supervision.

Naming disability a phenomenon was recommended by Love Worker to be able to address any questions or discomfort felt by the client or therapist.

Sasha identified ways the disability informs the EFT process and roadmap. She mentioned:

> So that's informing our stage one work because part of their cycle is that she gets very frustrated with his lack of follow-through around tasks around the home. And, so we've needed to really make sense of what this disability, how that disability, how that short term memory loss informs his seeming lack of responsiveness to her and trying to help her soften for both of them to organize that experience to put it into their cycle, understand how that disability, so that's an example of stage one work I think, around a disability.

The exploration of the impact of disability on the relationship allowed Sasha to incorporate the disability into the EFT cycle to conceptualize the process.

Lastly, Dolly approached serving her interabled couple within the EFT model a little differently. She explained:

> I was more looking for bonding moment and just seeing where that leads us…and hopefully that would be a bonding moment or at least a new moment or different moment, but the same markers of de-escalation or stayed to change events. I just threw those out the window.

Through the various ways participants responded to the disability in couple therapy, Dolly identified different markers to focus on within her interabled couple which included focus on bonding moments. While many participants shared adaptions to the EFT process, recommendations were also provided by majority of participants in identifying ways to support therapists serving interabled couples.

Future Recommendations

Future recommendations were highlighted by many participants in identifying their needs to better serve interabled couples. The most common recommendation shared was a training on interabled couples. For example, Love Worker stated: "I think there needs to be a training on doing EFT with interabled couples. I think that would be a fabulous masterclass."

In addition to a training being offered, Mimi mentioned the utility of having video examples. She shared:

> I guess the first thing that comes to my mind is the videos because that's such a helpful learning tool to be able to see someone working in this area. I mean, I think there could be a really fertile ground for some formal training around this piece.

Mimi and Love Worker both mentioned a formal training to serve interabled couples as well as a video example as a therapist tool for support.

Within a training on interabled couples, Sasha reported the importance of representation within trainings and discussions around interabled couples. She shared: "Representation, I think is a big one. Yeah, right? People just need to be thinking about it, right? And seeing more couples that are interabled. Yeah. So, I think representation and training materials."

Furthermore, Jack recommended the continued support of a supervisor while serving couples, specifically interabled couples. He stated:

> Since I started my private practice, I maintain supervisor and I regularly see my supervisor, and the reason is because there's no way I can process my own issues by myself…I've learned that very early in my career, to do this. And I teach also my supervisees the same way, that you can't assume that once you become private practice or you become a licensed therapist you can just do things on your own.

Jack reported the practice of maintaining a supervisor far beyond licensure to uphold a strong clinical practice.

Lastly, Sophia recommended a reference list when serving interabled couples. She mentioned:

> Yeah. It would be kind of nice maybe to have a reference list. For example, when couples are coming in, and some of the pain and stuff that they have has not been addressed by their primary care physician, by the physical therapist, or whoever they're seeing, and they mention some other problem associated with their disability.

In examining the needs of interabled couples, Sophia considered a reference list as a starting point to identify potential needs and referrals.

APPENDIX D

DISCUSSION

The purpose of this study was to examine the lived experiences of EFT Therapists serving interabled couples in couple therapy. I further sought to understand the ways therapists modified or adapted their work for interabled couples. By answering the established research question, this study affirmed, built upon, and added to the extant literature on EFT and serving clients with disabilities, more specifically, interabled couples. The study resulted in four super-ordinate themes (a) ableism, (b) self-of-the-therapist, (c) relationship dynamics of interabled couples, and (d) the "fit" of EFT approach with interabled couples. The lived experiences of EFT therapists serving interabled couples varied in the ways they approached the topic of disability, modified interventions, and navigated their own emotional experiences. The study further highlighted and built upon the importance of understanding therapists' experiences due to the limited information available (Bell et al., 2018). I first explore experiences from participants that offer valuable information about understanding how therapists conceptualize and view clients with disabilities, the therapists' perceptions of fit between EFT and working with interabled couples, and finally, I discuss limitations and implications of findings in the current study.

Ableist Views

A common experience identified by most of the participants was viewing the client with a disability through a deficit-oriented lens. I interpreted these experiences through an ableism framework (Nario-Redmond, 2020) which includes deficit-oriented views and beliefs about PWDs. Deficit language became apparent through the analysis process as themes were being explored. Many participants described partners with a disability as "permanently damaged," "afflicted," and a "struggle." Ableism like other forms of discrimination have long standing histories in the U.S. and have informed the ways others view PWDs. In understanding the use of certain terms to describe PWDs, it is imperative to examine the history of ableism in the U.S.

As mentioned, models of disability have existed for many centuries which have shifted the ways PWDs are viewed and treated. Historically, PWDs were denied personhood, dehumanized, and seen as a negative result due to an act of god (Retief & Letšosa, 2018). For example, in the U.S., women with disabilities experienced forced sterilization during the 19th and 20th century, while other PWDs were forcefully institutionalized for having a disability (Morris, 1991). While PWDs make up the largest minoritized group in the U.S. (Brault, 2012), discrimination, oppression, and marginalization continue to play a role in the lived experiences of PWDs. Given the long history of negative views of PWDs, Park et al. (2003) concluded many individuals in their qualitative study reported their fear and disgust of catching an illness which resulted in avoiding PWDs based on their visible appearance. These examples of discrimination, prejudice, and oppression contribute to current views of PWDs. For example, ableism exists in many facets of life, such as employment. In the U.S., 76.8% of non-disabled people were employed compared to 35.9% of PWDs (Lauer & Houtenville, 2018), with living wages being less than non-disabled workers. PWDs have experienced a long history of inequity in regard to employment long before the Americans with Disabilities Act (ADA) of 1990 was passed. PWDs continue to experience barriers in obtaining gainful employment based on discrimination and marginalization (Nario-Redmond, 2020; Olkin, 2017).

Given the historical context of disability in society, activism within the disability community has continued to reclaim the word "disability" not as a deficit but a strength and part of self-identity (Olkin, 2017). The increased representation in of PWDs in media created opportunities to examine peoples' understanding of PWDs in society (i.e., in relationship, successful jobs, healthy relationships, and lives). The result of increased representation and disability activism may have confused both non-disabled and some disabled individuals

regarding proper use of the term “disability” and other terms such as, “wheelchair bound,” “autistic,” and “disabled.” In understanding the history of ableism in the U.S., views of deficit language vary among certain disability groups (i.e., people born with disability and people who acquire disabilities; Nario-Redmond, 2020). Within the last decade, the push for social and racial justice in society and various professions (e.g., field of mental health) requires an examination of the language used as well as an important factor in the therapeutic process.

Given that many participants in the current study utilized deficit-oriented language is not surprising considering the forces of ableism and ableist ideologies that exist in society. The majority of participants were not aware of ableism as a force contributing to their narrative and shared their experiences without direct awareness of the use of deficit-oriented language. Moreover, these forces and ideologies exist and, in this case, may be perpetuated in counseling practices for these participants. For example, one participant, Rose, reported that the word “disability” itself was, in essence, deficit-language. While Rose’s statement itself communicated ableist ideals, there are communities of disabled people as mentioned who use this very language to describe their identities and their experiences which is not inherently deficit-oriented but rather empowerment and part of their self-identity. Rose’s personal view of the word “disability” has the potential to contribute to her professional conceptualization of a client with a disability, specifically interabled couples. The use of deficit-oriented language in describing people further perpetuates ableist ideals and reduces equitable access and inclusiveness. Given seven participants used deficit language, this study affirmed the presence of covert ableism in counseling conceptualization that may influence the therapist’s ability to serve clients from a disability-responsive lens rather than from a deficit lens. Furthermore, the acknowledgment and

examination of ableism as a force in therapy may yield additional recommendations for training and supervision around disability-responsive practices.

Medical Model as Contributor to Ableism

The medical model of disability has provided context and information throughout history to describe the perceptions of PWDs. Participants in the current study seemed to be heavily influenced by the medical model in conceptualizing their clients. For example, one participant, Sophia, described her client as being "permanently damaged" where "doctors couldn't repair" the partner. When Sophia described the situation the interabled couple experienced, the language used was derived from the medical model which views PWDs as "needing to be fixed or cured" to be accepted. All participants described the caution they felt when serving interabled couples, as many mentioned the desire to "get it right" when discussing disability. Addressing the differences in models of disability are important to the clinical development of therapists serving clients with disabilities. Understanding models of disability and ableism provide opportunities for therapists to increase their own awareness about internalized ableist messages and beliefs.

The experiences of some participants highlight the influence of ableism in professional practice and the impact of limited knowledge in serving clients with disabilities. The responses from a few participants were mindful of ableism and were cautious to not contribute to ableist practices and language. Other participants shared their experiences of serving interabled couples from a deficit-oriented lens. Their perceptions and views of disability may directly impact their conceptualization of the presenting issues and overall treatment (Rivas & Hill, 2017). In qualitative analysis, Rivas and Hill (2017) noted the theme of medicalization regarding the therapist's ability to conceptualize clients with disabilities. In the Rivas and Hill (2017) study, participants described seeing the disabled clients' issues through a medicalized narrative which

often came from information based on psychopathology (i.e., DSM). Additionally, they reported that within conceptualization was the issue of not identifying the stigma, discrimination, marginalization, and oppression often experienced by PWDs.

The therapist's conceptualization of the interabled relationship and presenting issues directly impacts decision-making in session, such as what is explored, what information is asked, interventions, and overall treatment. The negative impact to the therapist's conceptualization varies based on their level of self-work and understanding of disability from a strength-based perspective. This study adds to the literature, specifically following the Rivas and Hill (2017) findings that counselors-in-training with limited training in disability often conceptualized disability from a medicalized narrative. Utilizing a medicalized or deficit-oriented lens to conceptualize interabled couples may create opportunities to unknowingly cause harm to the therapeutic process and perpetuate ableist ideals (Leigh et al., 2004; Rivas & Hill, 2017).

Impact of Ableism on Therapeutic Process

Participants in this study shared increased caution in serving interabled couples. Many reported the fear of saying something incorrect and hurting the disabled partner's feelings. The participants' fears appeared to be rooted in empathy and compassion in not wanting to disrupt the therapeutic relationship. For example, Rose mentioned one interabled couple where the disabled partner had speech limitations due to acquiring a disability. She continued to state that after a few times of asking to re-state himself, she could not continue asking due to feeling guilty. She shared continuing the therapy even if she did not understand him. She was fearful of asking the disabled partner to constantly repeat himself. Rose's decision to not interrupt the disabled partner for clarification has potential to impact the disabled partner's feelings of safety and being understood. Furthermore, there was a concern from participants in focusing on the

disability too much during therapy. Many participants shared working to find a balance of when to discuss the partner's disability and when to allow the partner space to speak about their disability. These experiences shared by many participants emphasize the importance of examining beliefs about disabilities held by therapists serving interabled couples. As discussed, ableism is a powerful force in society that has universal impact. Given the deficit-oriented language of many participants, examining therapists' beliefs and understanding of disability provides an opportunity to prevent potential harm, disruptions, and ruptures in the therapeutic relationship. Additionally, exploring therapists' beliefs and understandings of disability allow for ableist views to be unlearned and an opportunity to relearn disability-responsive practices. This study adds to the literature around understanding therapists experiences serving interabled couples, specifically, how ableism can contribute to the therapeutic process and potential outcome if not explored explicitly.

Training in Serving Interabled Couples

In preparation for the current study, four accredited bodies were examined to identify the disability-related content described as being required during clinical training (APA, 2019; CACREP, 2020; COAMFTE, 2020; CSWE, 2020). Of the four accredited bodies, limited information was provided about discussing topics around disability outside of one course on multiculturalism (i.e., diversity or social cultural). In non-rehabilitation programs, educational content on disability and exposure to ableist practices may be limited. In various education programs, mental health professionals in training may be exposed and trained under the medical model of disability (i.e., diagnostic statistical manual 5 and other medicalized treatment options; Hogan, 2019; Santoro et al., 2017). While various professional code of ethics (ACA, 2014; American Association for Marriage and Family Therapy, 2015; American Psychological

Association, 2017; National Association of Social Workers, 2017) emphasize the importance of competence serving diverse communities, many professionals do not get trained in disability-responsive practices during their graduate-level training. The lack of training around serving clients with disabilities allows the potential to perpetuate ableist ideals and ideologies. This is reflected in the present study as the majority of participants spoke about not receiving training in serving clients with disabilities during graduate training and post-graduation.

The majority of participants shared the importance of a need for training in serving interabled couples. In surveying psychologists' perceptions of serving clients with disabilities, Leigh et al (2004) found that a large gap in provider knowledge led to increased barriers in the therapeutic process. In the current study, one participant, Cristina, mentioned the importance of training in serving interabled couples to reduce barriers of interabled couples needing services but was unable to locate or identify a provider with experience or knowledge of interabled couples. Given the vast experiences of individuals who acquire disabilities and their relationship with the disability, exploring disability-responsive practices within couple therapy is warranted.

In addition to lack of training on serving interabled couples in EFT, participants seemed to lack self-awareness on personal levels of ableism. In their review of the literature, Tellier and Calleja (2017) noted a need for therapists to examine held beliefs about PWDs in order to mediate their assumptions and biases regarding disability. Alternatively, not addressing internalized assumptions and beliefs about PWDs can lead to harm caused to the therapeutic relationship which goes against various professional code of ethics (ACA, 2014; AAMFT, 2015; APA, 2017; NASW, 2017). As described, training programs often do not focus on disability-responsive practices serving PWDs which creates opportunities to offer therapists a self-of-the-therapist training centered on ableism to explore held beliefs (Olkin, 2017). A few participants

shared the importance of such a training for therapists to help improve service delivery working with interabled couples.

Interventions for Interabled Couples

Parker (1993) recommended utilizing a holistic approach in serving interabled couples. One participant from the current study, Love Worker, made this point by stating the need to provide holistic treatment within EFT. Additionally, collaboration between interabled couples and other professionals/providers were discussed by many participants as being a useful resource in supporting interabled couples. As part of serving interabled couples holistically, collaboration is crucial to the therapeutic process in not only addressing the relationship but additional needs of the interabled couple (Tellier & Calleja, 2017). Based on the qualitative findings of Rivas and Hill (2017), they recommended incorporating a systemic lens to serving clients with disabilities. Lastly, this study affirmed Rivas and Hill's (2017) findings as they identified a holistic approach and integrated framework which utilizes a systemic lens to support the needs of clients with disabilities.

EFT Fit as a Viable Approach to Serving Interabled Couples

As reported by all participants, EFT was viewed as a good fit for serving interabled couples. Studies have demonstrated the effectiveness of EFT after an onset of a disability or chronic illness (Chawla & Kafescioglu, 2012; Fitzgerald & Thomas, 2012; Naaman, 2009; Wiebe & Johnson, 2016) which further suggests the potential fit of serving interabled couples. Participants mentioned the power of a strength-based attachment focused approach in serving clients. Many reported the innate attachment needs of all humans situates EFT as an important approach to serving interabled couples. Parra-Cardona et al (2009) emphasized this point and stated many core components of EFT can be adapted to serve clients with disabilities.

Many participants reported adapting the EFT model to best fit their interabled couples. Each participant modified their approach based on the needs of the partner with a disability. Many reported the flexibility of EFT, such as Jack, who shared his process working with his interabled couples often required the process to go slower. Others had similar reports of slowing the process down in moving through the stages and steps of EFT. Dolly mentioned incorporating more behavioral components to her work due to concerns over the limitations of the partner with a disability.

Barriers in EFT trainings have been captured in previous studies that identified limited training examples focused on heteronormative non-disabled couples (Wiebe et al., 2016). Reports from participants indicated limited diverse examples during their EFT trainings and the impact it had on them working with diverse couples. Many mentioned relying on their EFT supervisor for support and others mentioned using empirical research to assist in serving diverse couples. Recently, ICEEFT approved trainers have incorporated more racially diverse and affirmative trainings in the wake of George Floyd's murder and Black Lives Matter movement, but little have focused on clients with disabilities or interabled couples.

Currently, there is no evidence-based practice for serving clients with disabilities (Artman & Daniels, 2010). This was also highlighted by the participants, as many mentioned the lack of training in serving interabled couples, specifically in EFT. Many participants advocated for a training to be provided to EFT therapists serving interabled couples. Within ICEEFT approved trainings in EFT, a few studies have examined therapists' experiences learning EFT. Bell et al (2018) reported many therapists feeling stuck and needing more examples during training. Consistent with Bell et al.'s (2018) recommendation to include examples of interabled

couples to increase and improve quality of inclusiveness during the training experience, findings from the current study support this recommendation.

EFT Supervision as an Avenue to Support Therapists and Interabled Couples

An additional aspect that suggested EFT as a viable approach to serving interabled couples is therapists' engagement in EFT supervision. All participants mentioned continuing their own supervision after meeting all their requirements for licensure and certification. All participants mentioned engaging in ongoing EFT supervision and consultation which allowed for additional layers of support. Participants shared the use of supervision as a benefit to improving the quality of care and services provides to all couples. While ICEEFT requires only eight hours of supervision to be certified, all participants were certified and continued supervision and consultation.

Although many participants mentioned obtaining supervision after becoming certified in EFT, participants shared limitations from supervision in serving interabled couples. Participants reported that their EFT supervisors had no experience serving interabled couples. Within EFT, literature on EFT supervisors is scarce. The process to become an approved EFT supervisor from ICEEFT is holding an EFT certification, 10 hours of mentorship from an approved trainer/supervisor, supervising three therapists in EFT, and a course on supervision (ICEEFT, 2021). While the process to become a supervisor may be extensive, limited information is known about the training in serving clients with disabilities. Considering the influences of ableism within the therapeutic space, supervisors may be unaware of the potential barriers from the EFT therapists during supervision. Additionally, without addressing the therapist's ableist ideals and parts of self that may be impacting therapy contribute to the potential for disruption in the therapeutic relationship in serving interabled couples.

Limitations

While the study produced various findings, there are several limitations that exist. The sample size of the study (n=10) poses limitations to transferability. For the purpose of this particular study, it was important to focus only on EFT therapists who serve couples. However, therapists who practice other theoretical approaches/models to couple therapy serving interabled couples were not included in this study. Future studies could examine the experiences of other non-EFT therapists serving interabled couples in couple therapy both quantitatively and qualitatively. The EFT therapists involved in the study shared experiences of serving interabled couples with an acquired physical disability which did not include partners with congenital disabilities. Future studies might explore this by including all types of disabilities in interabled couples. The current study focused on lived experiences of EFT therapists serving interabled couples', yet the interabled couples receiving couple therapy were not included in this particular study. The lack of interviews with interabled couples limits the perspective to therapists. Additionally, due to the nature of this qualitative study, there are no conclusions about effectiveness of EFT with interabled couples. The findings support better understanding of how EFT therapists work with interabled couples but methodology precludes any exploration of efficacy or outcomes of EFT with this population.

Implications for Clinical Practice

This study generated six implications for clinical practice. First, the findings suggest the importance of therapists examining themselves and their held beliefs and assumptions about PWDs. The self-of-the-therapist requires exploration of ableist ideals and unlearning and relearning beliefs about PWDs. The training for therapists would encourage a strength-based view of disability and expand on ways therapists contribute to ableism and can work towards

reducing barriers for interabled couples. This exploration leads to an increase in self-awareness and increased confidence to address identity differences within the therapeutic relationship. Given the various accrediting bodies for clinical training across professions, many emphasize the importance of exploring and examining the "self" as a mental health professional and ways therapists own history can influence the therapeutic process (APA, 2019; CACREP, 2020; COAMFTE, 2020; CSWE, 2020).

Second, in exploring self-of-the-therapist work, examining training programs is an important aspect of addressing these issues from the start of clinical training. Increasing disability-responsive and disability-affirmative content within courses provides trainees opportunities to work through their own barriers before serving clients with disabilities and is congruent with ethical codes set by various professional organizations (ACA, 2014; AAMFT, 2015; APA, 2017; NASW, 2017). Educators are encouraged to consider integrating disability-related content throughout the curriculum. As mentioned, 61 million Americans identify as having a disability (CDC, 2019), therapists are likely to serve clients with disabilities. Increasing discussions, case and clinical examples, and content about PWDs from a strength-based lens may reduce ableist ideals and ideologies from being perpetuated in the therapeutic relationship.

Additionally, the importance of holistic and integrated care became an important discussion among many participants in serving interabled couples. Often, interabled couples navigating a newly acquired disability are involved in several services with providers who may or may not be communicating with each other. Expanding the work of therapists from talk therapy solely to more collaborative forms of serving interabled couples may result in expanded outcomes.

Three additional implications for clinical practice are connected to EFT as an approach. First, recommendations for EFT model to be more inclusive of diverse couples, specifically, interabled couples provides therapists more resources to best support their clients. The EFT model can include a roadmap for serving interabled couples throughout the stages and steps. Including language and descriptions about disability provides therapists opportunities to feel confident and grounded in their work. Second, training is needed in EFT to serve interabled couples. The training includes clinical examples and opportunities to explore understandings and perceptions of PWDs and in the context of an interabled couple. An EFT training specific to interabled couples could explore disability-responsive practices and disability affirmative language that reduces medicalized narratives therapists may use in conceptualizing interabled couples. These clinical practice implications directly relate to the implications for research. Lastly, offering opportunities for EFT supervisors to engage in self-of-the-therapist training around interabled couples also provides support in supervising EFT therapists serving interabled couples (Aponte & Kissil, 2016; Sandberg & Knestel, 2011). Creating opportunities for both EFT therapists and EFT supervisors to engage in unlearning ableist ideals and relearning disability-responsive practices further promote the service delivery for interabled couples.

Based on the findings of this study, it is recommended that therapists work toward establishing disability-responsive practices. Part of disability-responsive practices is having the therapist work with interabled couples to help process personal assumptions and biases held about PWDs. Artman and Daniels's (2010) suggested working to prevent further relationship harm by both partners processing their adjusting to the disability. Hunt et al (2009) and Martire (2013) both recommended the importance of assessing the interabled couples' ability to advocate for their needs. As both partners work to adjust to the disability, understanding services available

to support the interabled couples' needs may be limited. Therapists have an opportunity to impact the couple by providing resources and support in meeting certain needs outside of the therapeutic space.

Implications for Research

This study generated four implications for research. First, participants identified the importance of hearing from interabled couples and identifying their needs. Torge (2013) identified the limitations in perspective represented in literature that do not capture experiences of interabled couples. The current study supports Torge's conclusions and highlights the necessity of including more voices within the therapeutic space. Little is known about interabled couples' experiences in couple therapy. Participants encouraged the inclusion of both voices within interabled couples. This inclusion would center around interabled couples' lived experience in EFT couple therapy. This has been reflected by researchers as an important component to improving service delivery of PWDs (Leigh et al., 2004). Hess and Perrone-McGovern (2016) explained the importance of including voices of clients with disabilities. Examining the experiences of interabled couples in couple therapy may yield information to improve service delivery. Additionally, including the voices of interabled couples receiving couple therapy provides opportunities to understand their perspectives and the implications for clinical practice. Examining interabled couples' experiences in EFT couple therapy can yield valuable information about modifications and adjustments made within EFT to improve therapeutic outcomes. Another recommendation is examining interabled couples' experiences of ableistic (i.e., oppressive and deficit-oriented) messages in couple therapy, specifically, its impact on the therapeutic relationship and outcome.

Within EFT longstanding research, many authors recommended expanding selection of participants to be more inclusive of diverse samples both from therapists and couples in EFT couple therapy both qualitatively and quantitively (Bell et al., 2018; Dalgleish et al., 2015; Koren et al., 2020; Wiebe et al., 2016). This study adds to the understanding of therapists serving a diverse group of individuals, interabled couples, and provides a qualitative exploration of the ways therapists make sense of their experiences. A large study examining diverse couples receiving EFT couple therapy provides an opportunity to understand the areas of strength and growth related to the model and potential barriers of therapists. Another implication for research is EFT therapists' perceptions of ableism within the therapeutic relationship, specifically, therapists own awareness and knowledge of ableism and its potential impact on the therapeutic process. As the forces of ableism are strong in society, understanding the ways ableism shows up in therapy either from the therapist or clients is imperative to the therapeutic relationship. Lastly, a longitudinal study of EFT therapists after engaging in self-of-the-therapist training on ableism can provide opportunities to examine long-term impact of working through negative held beliefs of PWDs.

APPENDIX E

IRB APPROVAL

IRB #: IRB-20-590
Title: Experiences of Emotionally Focused Therapists Serving Interabled Couples: An Interpretative Phenomenological Analysis
Creation Date: 10-10-2020
End Date:
Status: Approved
Principal Investigator: Deanne Ray
Review Board: UNT IRB Full Board
Sponsor:

Study History

Submission Type	Review Type	Decision
Initial	Exempt	Exempt

APPENDIX F

ELECTRONIC RECRUITMENT FLYER

ARE YOU AN EFT THERAPIST?

The University of North Texas Department of Counseling and Higher Education is conducting a research study on:

Experiences of Emotionally Focused Therapists (EFT) Serving Interabled Couples: An Interpretive Phenomenological Analysis

For the purposes of this study, **interabled couples** are defined as couples where one partner has an acquired disability and the other does not have a disability.

You are eligible to participate in this research study if you:

a) are a non-rehabilitation counseling master or doctoral level therapist with a degree in mental health counseling or related degree; licensed to practice, such as: licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), licensed clinical social worker (LCSW), licensed psychologist (PsyD/PhD), or other related license;
b) are currently providing or have provided services to at least one interabled couple;
c) have completed advanced training in EFT (i.e., externship and core skills) or certified by ICEEFT as an EFT therapist, supervisor, or trainer.

Each eligible participant is asked to complete a one-time interview via Zoom ranging between 45-90 minutes.

Interested in participating? Have questions? Need more information?
Please contact:

APPENDIX G

DEMOGRAPHIC QUESTIONNAIRE

First name:
Last name:
What is your age?
What is your identified gender?
- Male
- Female
- Transgender male
- Transgender female
- Gender variant/non-conforming
- Not listed: _____
- Prefer not to answer

What is your racial/ethnic identity (select all that apply)?
- American Indian
- Asian
- Black/African American
- Hispanic/Latinx/Latino/a
- Middle Eastern and North African
- Native American or Aleut
- Native Hawaiian or Pacific Islander
- White
- Other: _____

What is your highest degree completed?
- Masters Degree (MS, MA, MED)
- Doctoral Degree (Explain type of program, PhD, PsyD, etc.): _____
- Other: _____

What licenses or certifications do you hold?
Select the trainings you completed in Emotionally Focused Therapy:
- EFT Externship
- Core Skills 1
- Core Skills 2
- Core Skills 3
- Core Skills 4
- Intensives: (explain which ones)_____
- Other: (explain)_____

How many hours of EFT supervision have you completed, if any?
What is the length of time you have been serving couples using EFT?
How many interabled (e.g., one partner having a physical disability and the other partner identifying as nondisabled) couples have you served?

APPENDIX H

INFORMED CONSENT

TITLE OF RESEARCH STUDY: EXPLORING EXPERIENCES OF EMOTIONALLY FOCUSED THERAPISTS SERVING INTERABLED COUPLES: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS

RESEARCH TEAM: Dee Ray, Counseling and Higher Education, 940-565-3864, dee.ray@unt.edu; Jose Luis Tapia-Fuselier Jr., Counseling and Higher Education, josetapia@my.unt.edu; Ana G. Reyes, Counseling and Higher Education, 347-366-3875, anareyes2@my.unt.edu.

You are being asked to participate in a research study. Taking part in this study is voluntary. The investigators will explain the study to you and will any answer any questions you might have. It is your choice whether or not you take part in this study. If you agree to participate and then choose to withdraw from the study, that is your right, and your decision will not be held against you.

The study is a qualitative study that centers the experiences of Emotionally Focused Therapists who have served interabled couples in couple counseling. The goal is to explore in-depth themes related to ways therapists serve interabled couples within the model of Emotionally Focused Therapy (EFT).

You are being asked to take part in a research study about the experiences of Emotionally Focused Therapists who have served interabled couples in couple counseling.

Your participation in this research study involves a one-time in-depth semi-structured interview virtually using a secure HIPAA compliant platform-Zoom for about 45-90 minutes. More details will be provided in the next section.

You might want to participate in this study if you identify as an Emotionally Focused Therapist who desires to share your experience working with interabled couples. However, you might not want to participate in this study if you do not have the time to participate in a one-time interview.

You may choose to participate in this research study if you are:
((a) must be 18 years old or older and will not be excluded based on gender/racial/ethnic composition
(b) a non-rehabilitation counseling master or doctoral level therapist with a degree in mental health counseling or related degree; licensed to practice, such as: licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), licensed clinical social worker (LCSW), licensed psychologist (PsyD/PhD), or other related license,
(c) currently providing or have provided services to at least one interabled couple,
(d) have completed advanced training in EFT (i.e., externship and core skills) or certified by ICEEFT as an EFT therapist, supervisor, or trainer.

The reasonable foreseeable risks or discomforts to you if you choose to take part is minimal as the questions are focused on your experiences as a therapist, which you can compare to the possible benefit of gaining potential insight and an increase in understanding of the needs of interabled couples in couple therapy. You will not receive compensation for participation.

DETAILED INFORMATION ABOUT THIS RESEARCH STUDY: The following is more detailed information about this study, in addition to the information listed above.

PURPOSE OF THE STUDY: The purpose of this qualitative Interpretative Phenomenological Analysis (IPA) study is to examine the experiences of Emotionally Focused Therapists working with interabled couples in couple therapy. Emotionally Focused Therapist (EFT) is an evidence-based approach with gaps in knowledge respective to the EFT therapists' experiences working with interabled couples.

The research will be guided by the following research question. How do EFT Therapists make sense of their lived experience with working with interabled couples in couple therapy?

TIME COMMITMENT: The study is expected to last approximately 45-90 minutes in a one-time semi-structured interview. A follow-up after the data analysis has begun will take place via email to confirm accuracy of interpretation.

STUDY PROCEDURES:

1. Virtual secure HIPAA compliant platform selected (I.e., Zoom) for interviews.
2. Research team will be trained in Interpretative Phenomenological Analysis.
3. Participants to be recruited through Emotionally Focused Therapy listservs and Facebook announcements in EFT groups.
4. Participants interested will contact student investigator and be screened virtually for appropriateness.
5. Eligible Participants will sign informed consent to participate in study and complete demographic questionnaire.
6. Student Investigator will schedule one-time semi-structured interview for 45-90 minutes.
7. A semi-structured interview will be conducted using Zoom that includes 6-10 questions for 45-90 minutes.
8. The research will end once all 8-10 participants data has been analyzed and presented for dissertation defense.

AUDIO/VIDEO/PHOTOGRAPHY:

☐ **I agree** to be audio recorded/video recorded during the research study.
☐ **I agree** that the audio recorded/video recorded can be used in publications or presentations.
☐ **I do not agree** that the audio recorded/video recorded can be used in publications or presentations.
☐ **I do not agree** to be audio recorded/video recorded during the research study.

The recordings will be kept with other electronic data in a secure UNT OneDrive account for the duration of the study. To ensure identifiable information is secure, video recordings will be blurred after the interview is completed. All recordings will be destroyed upon completion of research. Transcripts of the interviews will be stored for three years after the completion of the study on campus of UNT with the PI. All participants will be informed of recordings and approval will be sought through signed informed consent.

POSSIBLE BENEFITS:
Potential benefits of participation in this research may include the therapists gaining insights into best practices. Participants may benefit from an increase in their understanding of the needs of interabled couples in couple therapy. Additionally, the fields of counseling and psychology could benefit from understanding the experiences of EFT Therapists serving interabled couples in couple therapy.

POSSIBLE RISKS/DISCOMFORTS:
Participation in this online survey involves risks to confidentiality similar to a person's everyday use of the internet and that there is always a risk of breach of confidentiality. The reasonable foreseeable risks include the potential for loss of confidentiality.

This research study is not expected to pose any additional risks beyond what you would normally experience in your regular everyday life. However, if you do experience any discomfort, please inform the research team.

National Suicide Prevention Hotline at 1-800-273-8255

Participating in research may involve a loss of privacy and the potential for a breach in confidentiality. Study data will be physically and electronically secured by the research team. As with any use of electronic means to store data, there is a risk of breach of data security.

If you experience excessive discomfort when completing the research activity, you may choose to stop participating at any time without penalty. The researchers will try to prevent any problem that could happen, but the study may involve risks to the participant, which are currently unforeseeable. UNT does not provide medical services, or financial assistance for emotional distress or injuries that might happen from participating in this research. If you need to discuss your discomfort further, please contact a mental health provider, or you may contact the researcher who will refer you to appropriate services. If your need is urgent, helpful resources include National Suicide Prevention Hotline at 1-800-273-8255.

COMPENSATION: No compensation will be offered to participate in the study. There are no alternative activities offered for this study.

CONFIDENTIALITY: Efforts will be made by the research team to keep your personal information private, including research study video recordings, and disclosure will be limited to people who have a need to review this information. All paper and electronic data collected from this study will be stored in a secure location on the UNT campus and/or a secure UNT server for at least three (3) years past the end of this research at the Center for Play Therapy at UNT in the PI's campus office. Research records will be labeled with a code and the master key linking names with codes will be maintained in a separate and secure location.

Participation in this virtual interview involves the potential for the loss of confidentiality similar to a person's everyday use of the internet.

The results of this study may be published and/or presented without naming you as a participant. The data collected about you for this study may be used for future research studies that are not described in this consent form. If that occurs, an IRB would first evaluate the use of any information that is identifiable to you, and confidentiality protection would be maintained.

While absolute confidentiality cannot be guaranteed, the research team will make every effort to protect the confidentiality of your records, as described here and to the extent permitted by law. In addition to the research team, the following entities may have access to your records, but only on a need-to-know basis: the U.S. Department of Health and Human Services, the FDA (federal regulating agencies), the reviewing IRB, and sponsors of the study.

This research uses a third party software called qualtrics and is subject to the privacy policies of this software noted here: https://www.qualtrics.com/support/survey-platform/getting-started/data-protection-privacy/

This research uses a third party software called Zoom and is subject to the privacy policies of this software noted here: https://zoom.us/privacy

CONTACT INFORMATION FOR QUESTIONS ABOUT THE STUDY: If you have any questions about the study you may contact Jose Tapia-Fuselier at [redacted]. Any questions you have regarding your rights as a research subject, or complaints about the research may be directed to the Office of Research Integrity and Compliance at 940-565-4643, or by email at untirb@unt.edu.

CONSENT:

- Your signature below indicates that you have read, or have had read to you all of the above.
- You confirm that you have been told the possible benefits, risks, and/or discomforts of the study.
- You understand that you do not have to take part in this study and your refusal to participate or your decision to withdraw will involve no penalty or loss of rights or benefits.
- You understand your rights as a research participant and you voluntarily consent to participate in this study; you also understand that the study personnel may choose to stop your participation at any time.
- By signing, you are not waiving any of your legal rights.

Please sign below if you are at least 18 years of age and voluntarily agree to participate in this study.

SIGNATURE OF PARTICIPANT **DATE**

***If you agree to participate, please provide a signed copy of this form to the researcher team. They will provide you with a copy to keep for your records.**

APPENDIX I

SEMI-STRUCTURED INTERVIEW SCHEDULE

Research Question: How do EFT Therapists make sense of their lived experience working with interabled couples in couple therapy?	
Interview Schedule	
Questions	Prompts (directly related to question)
1. What does the word "interabled couple" mean to you?	• How do you define it? • What image comes to mind as you describe interabled couples?
2. Can you think back to the first interabled couple that you served? Tell me about that experience.	• What did you notice about yourself in that experience? • How did you make meaning of one partner having a disability? • How did that meaning making impact your view of the client with the disability? • Did the disability inform your approach to serving the couple? • What did you do to modify your approach? • Is there one partner you saw more frequently individually?
3. How do you feel when you work with clients with disabilities?	• What makes you feel that way? • How do you overcome those challenges? • What resources, if any, do you use to inform your practice in serving clients with disabilities?
4. How have your experiences working with interabled couples changed you as a therapist?	• What did you learn about yourself through that process? • What was the most challenging part? • What was the most rewarding part? • What is unique about interabled couples than your couples with no disabilities?
5. How does the EFT approach fit with counseling interabled couples?	• What is different? • How, if at all, is EFT uniquely matched to serving interabled couples? • Did you navigate other systems of care with the interabled couples you served? • How might it be different? • How have you modified it to serve different types of couples?
6. How, if at all, can EFT be modified to better fit the needs of interabled couples?	• How did you come to learn this? • Have you applied these modifications? • Do they work? • Have you received any specific training?
7. Can you tell me about how EFT training(s) prepared you to serve interabled couples?	• What specific parts of the trainings did you find helpful? • What gaps do you think currently exist?
8. What do you think could help you serve interabled couples better at this time?	• What resources would be helpful in your practice?

COMPREHENSIVE REFERENCE LIST

Al-Dababneh, K. A., Fayez, M., & Bataineh, O. (2012). Needs of parents caring for children with physical disabilities: A case study in Jordan. *International Journal of Special Education, 27*(3), 120-133.

Ali, S. (2013, March). *A disability history timeline: The struggle for equal rights through the ages.* Mersey Care NHS Foundation. https://www.merseycare.nhs.uk/media/1749/disabilityt-timeline-2013.pdf

Allan, R., & Johnson, S. M. (2017). Conceptual and application issues: Emotionally focused therapy with gay male couples. *Journal of Couple & Relationship Therapy, 16*(4), 286-305. http://dox.doi.org/10.1080/15332691.2016.1238800

Allan, R., & Eatough, V. (2016). The use of interpretive phenomenological analysis in couple and family therapy research. *The Family Journal: Counseling and Therapy for Couple and Families, 24*(4), 406-414. https://doi.org/10.1177/1066-480716662652

Allan, R., & Ungar, M. (2012). Couple and family therapy with five physical rehabilitation populations: A scoping review. *Australian Journal of Rehabilitation Counselling, 18*(2), 107-134. https://doi.org/10.1017/jrc.2012.13

American Association for Marriage and Family Therapy (AAMFT; 2015). *Code of ethics.* https://www.aamft.org/Legal_Ethics/Code_of_Ethics.aspx

American Counseling Association (ACA; 2014). *Code of ethics.* https://www.counseling.org/Resources/aca-code-of-ethics.pdf

American Psychological Association (APA; 2019). *Accreditation policies and procedures.* https://www.accreditation.apa.org/policies?_ga=2.86889630.781632646.1588477159-650014095.1588477159

American Psychological Assocation (2017). *Ethical principles of psychologists and code of conduct.* https://www.apa.org/ethics/code

Aponte, H., & Kissil, K. (2016). *Person of the therapist training model.* Taylor and Francis.

Artman, L. K., & Daniels, J. A. (2010). Disability and psychotherapy practice: Cultural competence and practical tips. *Professional Psychology: Research and Practice, 41*(5), 442-448. https://doi.org/10.1037/a0020864

Aruma Disability Services. (2019, July 22). *Types of physical disabilities.* https://www.aruma.com.au/about-us/about-disability/types-of-disabilities/types-of-physical-disabiltiies/

Bakeman, R., & Gottman, J. M. (1986). *Observing interactions: An introduction to sequential analysis.* New York: Cambridge University Press.

Beasley, C. C., & Ager, R. (2019). Emotionally focused couples therapy: A systemic review of its effectiveness over the past 19 years. *Journal of Evidence-Informed Social Work, 16*(2), 144-159. https://doi.org/10.1080/23761407.2018.1563013

Bell, C. A., Denton, W. H., Martin, G., Coffey, A. D., Hanks, C. O., Cornwell, C. S., & Priest, J. B. (2018). Learning emotionally focused couple therapy: Four clinicians' perspectives. *Journal of Couple & Relationship Therapy, 17*(1), 61-78. https://doi.org/10.1080/15332691.2017.1310638

Berg, C. A., & Upchurch, R. (2007). A developmental-contextual model of couples coping with chronic illness across the adult life span. *Psychological Bulletin, 133*, 920-954.

Berryman, M., Ford, T., Nevin, A, & Soohoo, S. (2015). Culturally responsive contexts: Establishing relationships for inclusion. *International Journal of Special Education, 30*(3), 39-51.

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: A tool to enhance trustworthiness or merely a nod to validation? *Qualitative Health Research, 26*(13), 1802-1811. https://doi.org/10.1177/1049732316654870

Blow, A. J., Curtis, A. F., Wittenborn, A. K., & Gorman, L. (2015). Relationship problems and military related PTSD: The case for using emotionally focused therapy for couples. *Contemporary Family Therapy, 37*(3), 261-270.

Bouchard, K., Greenman, P., Pipe, A., Johnson, S., & Tulloch, H. (2019). Reducing caregiver distress and cardiovascular risk: A focus on caregiver-patient relationship quality. *Canadian Journal of Cardiology, 35*(10), 1409-1411

Bowlby, J. (1969). *Attachment and loss: Attachment, Vol 1.* New York: Basic Books.

Brault, M. W. (2012). Americans with disabilities: 2010. Current population reports, P70-131. Washington, DC: US Census Bureau. https://www.census.gove/prod/2012pubs/p70-131.pdf

Brubacher, L. (2017). Emotionally focused individual therapy: An attachment-based experiential/systemic perspective. *Person-Centered & Experiential Psychotherapies, 16*(1), 50-67. https://doi.org/10.1080/14779757.2017.1297250

CACREP. (2019, October 11). *Section 5: Rehabilitation counseling.* https://www.cacrep.org/section-5-entry-level-specialty-areas-rehabilitation-counseling/

Canavarro, M. C., & Dattilio, F. M. (2011). Family therapy and medical issues. *Contemporary Family Therapy, 33*, 87-90. https://doi.org/10.1007/s10591-011-9150-x

Centers for Disease Control and Prevention (2017). *Marriages and divorces*. Retrieved from https://www.cdc.gov/nchs/nvss/marriage_divorce_tables.htm

Center for Disease Control and Prevention (2019). Disability impacts all of us. https://www.cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html

Chawla, N., & Kafescioglu, N. (2012). Evidence-based couple therapy for chronic illnesses: Enriching the emotional quality of relationships with emotionally focused therapy. *Journal of Family Psychotherapy, 23*, 42-53. https://doi.org/10.1080/08975353.2012.654080

Chayaput, P., Utriyaprasit, K., Bootcheewan, S., & Thosingha, O. (2014). Coping and health problems of caregivers of survivors with traumatic brain injury. *Aquichan, 14*(2), 170-183.

Cloutier, P. F., Manion, I. G., Walker, J. G., & Johnson, S. M. (2002). Emotionally focused interventions for couples with chronically ill children: A 2-year follow-up. *Journal of Marital and Family Therapy, 28(*4), 391-398.

Cohen, C. B., & Napolitano, D. (2007). Adjustment to disability. *Journal of Social Work in Disability & Rehabilitation, 6*(½), 135-155. https://doi.org/10.1300/J198v06n01_08

Commission on Accreditation for Marriage and Family Therapy Education (20190. *Accreditation manual: Policies and procedures.* https://www.coamfte.org/documents/COAMFTE/COAMFTE%20Accreditation%20Manual%20Policies%20and%20Procedures.pdf

Council on Social Work Education (CSWE; 2020). *Commission on Accreditation.* https://www.cswe.org/Accreditation

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.) Thousand Oaks, CA: Sage.

Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five traditions.* (3rd ed.) Thousand Oaks, CA: Sage.

Czyż, A. (2017). Early support development of children with disorders of the biopsychosocial functioning in Poland. *Bulgarian Comparative Education Society, 15*, 209-216.

Dalgleish, T. L., Johnson, S. M., Burgess Moser, M., Lafontaine, M-F., Wiebe, S. A., & Tasca, G. A. (2015). Predicting change in marital satisfaction throughout emotionally focused couple therapy. *Journal of Marital and Family Therapy, 41*(3), 276-291. https://doi.10.1111/jmft.12077

Day, M. C. (2013). The role of initial physical activity experiences in promoting posttraumatic growth in paralympic athletes with an acquired disability. *Disability and Rehabilitation, 35*(24), 2064-2072. https://doi.org/10.3109/09638288.2013.805822

Dickson, A., Ward, R., O'Brien, G., Allan, D., & O'Carroll, R. (2011). Difficulties adjusting to post-discharge life following a spinal cord injury: An interpretative phenomenological

analysis. *Journal of Psychology, Health & Medicine, 16*(4), 463-474. http://doi.org/10.1080/13548596.2011.555769

East, L. J., & Orchard, T. R. (2014). Somebody else's job: Experiences of sex education among health professionals, parents and adolescents with physical disabilities in Southwestern Ontario. *Sex Disability, 32*, 335-350. https://doi.org/10.007/s11195-013-9289-5

El Ghatit, A., & Hanson, R. (1975). Outcome of marriages existing at the time of a male's spinal cord injury. *Journal of Chronic Diseases, 28*(1), 383-388.

Elman, C., Gerring, J., & Mahoney, J. (2016). Case study research: Putting the quant into the qual. *Sociological Methods & Research, 45*(3), 375-391. https://doi.org/10.1177/004912416644273

Eriksen, W., Natvig, B., & Bruusgaard, D. (1999). Marital disruption and long-term work disability. *Scand J Public Health, 27*, 196-202.

Esmail, S., Huang, J., Lee, I., & Maruska, T. (2010a). Couple's experiences with men are diagnosed with multiple sclerosis in the context of their sexual relationship. *Sexuality and Disability, 28*, 15-27. https://doi.org/10.1007/s11195-009-9144-x

Esmail, S., Darry, K., Walter, A., & Knupp, H. (2010b). Attitudes and perceptions twards disability and sexuality. *Disability and Rehabilitation, 32*(14), 1148-1155. https://doi.org/10.3109/09638280903419277

Fekete, E. M., Stephens, M., Mickelson, K. D., & Druley, J. (2007). Couples' support provision during illness: The role of perceived emotional responsiveness. *Families, Systems, and Health, 25*(2), 204-217.

Fitzgerald, J., & Thomas, J. (2012). A report: Couples with medical conditions, attachment theoretical perspectives and evidence for emotionally focused couples therapy. *Contemporary Family Therapy, 34*, 277-281. https://doi:10.1007/s10591-012-9184-8

Forber-Pratt, A. J., Lyew, D. A., Mueller, C., & Samples, L. B. (2017). Disability identity development: A systemic review of the literature. *Rehabilitation Psychology, 62*(2), 198-207. http://dx.doi.org/10.1037/rep0000134

Forber-Pratt, A. J., & Zape, M. P. (2017). Disability identity development model: Voices from the ADA-generation. *Disability and Health Journal, 10*, 350-355. http://dx.doi.org/10.1016/j.dhjo.2016.12.013

Geller, S. M., & Porges, S. W. (2014). Therapeutic presence: Neurophysiological mechanisms mediating feeling safe in therapeutic relationships. *Journal of Psychotherapy Integration, 24*(3), 178-192. http://dx.doi.org/10.1037/a0037511

Ghedin, S., Semi, A., Caccamo, F., Caldironi, L., Marogna, C., Piccione,F., Stabile, R., Lorio, R., & Vidotto, G. (2017). Emotionally focused couple therapy with neurodegenerative

diseases: A pilot study. *The American Journal of Family Therapy, 45*(1), 15-26. http://dx.doi.org/10.1080/01926187.2016.1223562

Gordon, P. A., Feldman, D., & Chiriboga, J. (2005). Helping children with disabilities develop and maintain friendships. *Teacher Education and Special Education, 28*(1), 1-9.

Gordon, P. A., & Perrone, K. M. (2004). When spouses become caregivers: Counseling implications for younger couples. *Journal of Rehabilitation, 70*(2), 27-32.

Grayer, J. (2016). Emotionally focused therapy for couples: A safe haven from which to explore sex during and after cancer. *Sexual and Rehabilitation Therapy, 31*(4), 488-492.

Greenman, P. S., & Johnson, S. M. (2012). United we stand: Emotionally focused therapy (EFT) for couples in the treatment of post-traumatic stress disorder. *Journal of Clinical Psychology: In Session, 68*(5), 561-569.

Harding, S. (1993). Rethinking standpoint epistemology: What is "strong objectivity"? in L. Alcoff & E. Potter (Eds.), *Feminist epistemologies* (pp. 49-82). New York, NY: Routledge.

Hebbeler, K., & Spiker, D. (2016). Supporting young children with disabilities. *Future of Children, 26*(2), 185-205.

Hess, R. A., & Perrone-McGovern, K. M. (2016). Quality of life for individuals with traumatic brain injury: The influence of attachment security and partner support. *Journal of Rehabilitation, 82*(4), 14-27.

Hesse-Biber, S. N. (2017). *The practice of qualitative research engaging students in the research process.* Los Angeles, CA: Sage.

Hogan, A. J. (2019). Moving away from the "medical model": The development and revision of the world health organization's classification of disability. *Bulletin of the History of Medicine, 93*(2), 241-269. https://doi.org/10.1353/bhm.2019.0028

Hughes, A., Hertlein, K., & Hagey, D. (2011). A medft-informed sex therapy for treating sexual problems associated with chronic illness. *Journal of Family Psychotherapy, 22*, 114-127.

Hunt, B., Milsom, A., Matthews, C. R. (2009). Partner-related rehabilitation experiences of lesbians with physical disabilities. *Rehabilitation Counseling Bulletin, 52*(3), 167-178. https://doi.org/10.1177/0034355208320933

Hwang, K., Johnston, M., & Smith, J. K. (2007). Romantic attachment in individuals with physical disabilities. *Rehabilitation Psychology, 52*(2), 184-195. https://doi.org/10.1037/00905550.52.2.184

International Center for Excellence in Emotionally Focused Therapist (2021). *Level 2: Certified EFT supervisor.* https://iceeft.com/level-2-certified-eft-supervisor/

Janus, A. L. (2009). Disability and the transition to adulthood. *Social Forces, 88*(1), 98-120.

Johnson, S. M. (2019). Attachment theory in practice: Emotionally focused therapy (EFT) with individuals, couples, and families. Guilford Publication.

Johnson, S. M. (2004). *The practice of emotionally focused couple therapy: Creating connection.* New York, NY: Brunner-Routledge.

Johnson, S. M., & Greenman, P. S. (2006). The path to a secure bond: Emotionally focused couple therapy. *Journal of Clinical Psychology, 62*(5), 597-609. https://doi.org/10.1002/jclp.20251

Johnson, S. M., Hunsley, J., Greenberg, L., & Schindler, D. (1999). Emotionally focused couples therapy: Status and challenges. *Clinical Psychology: Science and Practice, 6*, 67-79.

Johnston, L., & Terp, D. M. (2015). Dynamics in couples facing early Alzheimer's disease, *Clinical Gerontologist, 38*(4), 283-301. https://doi.org/10.1080/07317115.2015.1032465

Kim, Y. (2011). The pilot study in qualitative inquiry: Identifying issues and learning lessons for culturally competent research. *Qualitative Social Work, 10*(2), 190-206.

Kreuter, M. (2000). Spinal cord injury and partner relationships. *The Scientific Review, 38*, 2-6.

Koren, R., Woolley, S. R., Danis, I., & Török, S. (2020). Measuring the effectiveness of the emotionally focused therapy externship training in Hungary done through translation. *Journal of Marital and Family Therapy, 1*, 1-17. https://doi.org/10.111/jmft.12443

Larkin, M., & Thompson, A. (2012). Interpretative phenomenological analysis. In A Thompson & D Harper (Eds), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners.* Jon Wiley & Sons.

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology, 3*, 102-120. https://doi.org/10.1191/1478088706qp062oa

Larrison, C. R., & Schoppelrey, S. L. (2011). Therapist effects on disparities experienced by minorities receiving services for mental illness. *Journal of Research on Social Work Practice, 21*(6), 727-736. https://doi.org/10.1177.1049731511410989

Lauer, E. A., & Houtenville, A. J. (2018). *Annual disability statistics compendium: 2017.* Durham, HS: University of New Hampshire, Institute on Disability.

Leigh, I. W., Powers, L., Vash, C., & Nettles, R. (2004). Survey of psychological services to clients with disabilities: The need for awareness. *Rehabilitation Psychology, 49*(1), 48-54. https://doi.org/10.1037/0090-5550.49.1.48

Linhof, A. Y., & Allan, R. (2019). A narrative expansion of emotionally focused therapy with intercultural couples. *The Family Journal: Counseling and Therapy for Couples and Families, 27*(1), 44-49. https://doi.org/10.1177/1066480718809426

Livneh, H., & Antonak, R. F. (2005). Psychosocial adaptation to chronic illness and disability: A primer for counselors. *Journal of Counseling and Development, 83*(1), 12-20.

Livneh, H., Wilson, L. M., & Pullo, R. E. (2004). Group counseling for people with physical disabilities. *Focus on Exceptional Children, 36*(6), 1-18.

Lorenz, D. C. (2008). Can I play? Therapy for children and adolescents with disabilities. *Vitas Online, 7.* 1-11.

Martire, L. M. (2013). Couple-oriented interventions for chronic illness: Where do we go from here? *Journal of Social and Personal Relationships, 30*(2), 207-2014. https://doi.org/10.1177/0265407512453786

Mattlin, B. (2019). *In sickness and in health: Love, disability, and a quest to understand the perils and pleasures of interabled romance.* Beacon Press.

McGregor, L. M., Dickson, A., Flowers, P., Hayes, P. C., & O'Carroll, R. E. (2014). Reclaiming their lives: The decision-making process in living liver donation-An interpretative phenomenological case study analysis of one couple. *Psychology & Health, 29*(12), 1373-1387. https://doi.org/10.1080/08870446.2014.940950

McLean, L. M., Walton, T., Rodin, G., Esplen, M. J., & Jones, J. M. (2013). A couple-based intervention for patients and caregivers facing end-stage cancer: Outcomes of a randomized controlled trial, *Psycho-Oncology, 22*, 28-38. https://doi.org/10.1002/pon.2046

Merriam, S. B., & Tisdell, E. J. (2016). *Qualitative research: A guide to design and implementation.* San Francisco, CA: Jossey-Bass.

Milbury, K., Badr, H., Fossella, F., Pisters, K. M., & Carmack, C. L. (2013). Longitudinal associates between caregiver burden and patient and spouse distress in couples coping with lung cancer. *Support Care Cancer, 21*, 2371-2379. https://doi.org/10.1007/s00520-013-1795-6

Moustakas, C. E. (1994). *Phenomenological research methods.* Thousand Oaks, CA: Sage.

Miller, R. M., Chan, C. D., & Famer, L. B. (2018). Interpretative phenomenological analysis: A contemporary qualitative approach. *Counselor Education & Supervision, 57*(1), 240-254. https://doi.org/10.1002/ceas.12114

Montagno, M., Svatovic, M., Levenson, H. (2011). Short-term and long-term effects of training in emotionally focused couple therapy: Professional and personal aspects. *Journal of Marital and Family Therapy, 37*(4), 380-392. https://doi.org/10.1111/j.1752-0606.2011/00250.x

Morris, J. (1991). *Pride against prejudice: Transforming attitudes to disability.* New Society.

Naaman, S., Radwan, K., & Johnson, S. (2009). Coping with early breast cancer: Couple adjustment processes and couple-based interventions, *Psychiatry, 72*(4), 321-345.

Najafi, M., Soleimani, A. A., Ahmadi, K., & Kamkar, E. H. (2015). The effectiveness of emotionally focused therapy on enhancing marital adjustment and quality of life among infertile couples with marital conflicts. *International Journal of Fertility & Sterility, 9*(2), 238-246. https://doi.org/10.22074/ijfs.2015.4245

Nario-Redmond, M. R. (2019). *Ableism, the causes and consequences of disability prejudice.* John Wiley & Sons, Incorporated.

National Association of Social Workers (NASW; 2017). *Code of ethics.* https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

National Disability Authority. (2015). *Appropriate terms to use.* https://nda.ie/Publications/Attitudes/Appropriate-Terms-to-Use-about-Disability/

Olkin, R. (2017). *Disability-affirmative therapist: A case formulation template for clients with disability.* Oxford University Press.

Ostrosky, Y. S., & Fowler, M. M., (2011). Children's friendship development: A comparative study. *Early Childhood Research & Practice, 13*(1), 1-16.

Park, J. H., Faulkner, J., & Schaller, M. (2013). Evolved disease-avoidance processes and contemporary anti-social behavior: Prejudicial attitudes and avoidance of people with physical disabilities. *Journal of Nonverbal Behavior, 27*(2), 65-87. https://doi.org/10.1023/A:1023910408854

Parker, G. (1993). Disability, caring and marriage: The experience of younger couples when a partner is disabled after marriage. *British Journal of Social Work, 23*, 565-580.

Parra-Cardona, J. R., Coórdova, D., Holtrop, K., Escobar-Chew, A. R., & Horsford, S. (2009). Culturally informed emotionally focused therapy with latino/a immigrant couples. In Rastogi, M., & Thomas, V. (ed.) Multicultural Couple Therapy (pp. 345-368). Sage Publications

Patton, M. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.

Porat, O., Heruti, R., Navon-Porat, H., & Hardoff, D. (2012). Counseling young people with physical disabilities regarding relationships and sexuality issues: Utilization of a novel service. *Sex and Disability, 30*, 311-317. https://doi.org/10.1007/s11195-011-9241-5

Price, M. S. (2011). Special needs adults and divorce issues. *American Journal of Family Law,* 168-174.

Psych Central. (2019, June 19). *Mental health professionals: US statistics 2011.* https://psychcentral.com/lib/mental-health-professionals-us-statistics/

Retief, M., & Letšosa, R. (2018). Models of disability: A brief review. *HTS Teologiese Studies/Theological Studies, 74*(1), 1-8. https://doi.org/10.4102/hts.v74i1.4738

Rivas, M., & Hill, N. R. (2017). Counselor trainees' experiences counseling disability: A phenomenological study. *Counselor Education & Supervision, 57*, 116-131. https://doi.org/10.1002/ceas.12097

Rivera, P. A., Elliott, T. R., Berry, J. W., Shewchuk, R. M., Oswald, K. D., & Grant, J. (2006). Family caregivers of women with physical disabilities. *Journal of Clinical Psychology in Medical Settings, 13*, 431-440. https://doi.org/10.1007/s10880-006-9043-6

Roebuck, D. C., & Reid, K. (2019). How trainee therapists experience resilience: An interpretative phenomenological analysis. *Journal of Counseling and Psychotherapy Research, 20*(3), 545-555. http://doi.org/10.1002/capr.12286

Rogow, S. (2005). A developmental model of disabilities. The International Journal of Special Education, 20(2), 132-135.

Rolland, J. S., (2018). Helping couples and families navigate illness and disability: An integrated approach. New York, London: The Guilford Press

Stake, R. E. (1995). *The art of case study research.* Thousand Oaks, CA: Sage.

Rossheim, B. N., & McAdams, C. R. (2010). Addressing the chronic sorrow of long-term spousal caregivers: A primer for counselors. *Journal of Counseling and Development, 88*(4), 477-488.

Sandberg, J. G., & Knestel, A. (2011). The experience of learning emotionally focused couples therapy. *Journal of Marital and Family Therapy, 37*(4), 393-410. https://doi.org/10.1111/j.1752-0606.2011.00254.x

Santoro, J. D., Yedla, M., Lazzareschi, D. V., & Whitgob, E. E. (2017). Disability in US medical education: Disparities, programs and future directions. *Health Education Journal, 76*(6), 753-759. http://dx.doi.org/10.1177/0017896917712299

Shewchuk, R. M., Rivera, P. A., Elliott, T. R., & Adams, A. M. (2004). Using cognitive mapping to understand problems experienced by family caregivers of persons with severe physical disabilities. *Journal of Clinical Psychology in Medical Settings, 11*(3), 141-150. https://doi.org/1068-9583/04/0900-0141/0

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. Health Psychology Review, 5(1), 9-27. https://doi.org/10.1080/17437199.2010/510659

Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative resource in psychology. *Qualitative Research in Psychology, 1*, 39-54. https://doi.org/10.1191/1478088704qp004oa

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* Sage.

Smith, J. A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (p. 50-81). Sage.

Spengler, E. S., DeVore, E. N., & Lee, N. A. (2019). What does "couple" mean in couple therapy outcome research? A systematic review of the implicit and explicit, inclusion and expclusion of gender and sexual minority individuals and identities. *Journal of Marital and Family Therapy, 46*(2), 240/255. https://doi.org/10.1111/jmft.12415

Stake R. E. (1995) *The art of case study research.* Sage.

Stein, J., Hillinger, M., Clancy, C., & Bishop, L. (2013). Sexuality after stroke: Patient counseling preferences. *Disability and Rehabilitation, 35*(21), 1842-1847. https://doi.org/10.3109/09638288.2012.754953

Stiell, K., Naaman, S., & Lee, A. (2007). Couples and chronic illness: An attachment perspective and emotionally focused therapy interventions. *Journal of Systemic Therapists, 26*(4), 59-74.

Sweeney, K. K., Horne, S. G., & Ketz, K. (2015). Sexual orientation, body image, and age as predictors of sexual self-schema for women with physical disabilities. *Sexuality and Disability, 33,* 313-326. https://doi.org/10.1007/s11195-015-9399-3

Tapia-Fuselier, J. L., Jr., & Ray, D. (2019). Culturally and linguistically responsive play therapy: Adapting child-centered play therapy for deaf children. *International Journal of Play Therapy, 28*(2), 79-87. https://doi.org/10.1037/pla0000091

Tellier, S. A., & Calleja, N. G. (2017). Renegotiating sexuality following an acquired disability: Best practices for counselors. *Adult Life Span Journal, 16*(1), 47-59. https://doi.org/10.1002/adsp.12033

Thwala, S. K., Ntinda, K., & Hlanze, B. (2015). Lived experiences of parents' of children with disabilities in Swaziland. *Journal of Education and Training Studies, 3*(4), 206-215.

Tie, S., & Poulen, S. (2013). Emotionally focused couple therapy with couples facing terminal illness. *Contemporary Family Therapy, 35*, 557-567. https://doi.org/10.1007/s10591-013-9238-6

Torge, C. J. (2013). Using conjoint interviews with couples that have been living with disabilities and illnesses for a long time – implications and insights. *Qualitative Studies, 4*(2), 100-113.

Torpey, E. (2018, March 13). *Careers in social work: Outlook, pay, and more: Career outlook.* U.S. Bureau of Labor Statistics. https://www.bls.gov/careeroutlook/2018.article/social-workers.htm

U.S. Bureau of Labor Statistics. (2018, May). *Marriage and family therapists.* https://www.bls.gov/oes/2018/may/oes211013.htm#(1)

U.S. Bureau of Labor Statistics. (2020, April 22). *Psychologists: Occupational outlook. Handbook: U.S Bureau of Labor Statistics.* https://www.bls.gov/ooh/life-physical-and-social-science/psychologists.htm#tab-6

U.S. Bureau of Labor Statistics. (2016, May). *Mental health counselors.* https://www.bls.gov/oes/2016/may/oes211014.htm

U.S. Census Bureau (2012). Nearly 1 in 5 people have a disability in the U.S., census bureau reports released to coincide with 22nd anniversary of the ADA. Retrieved from https://www.census.gov/newsroom/releases/archives/miscellaneous/cb12-134.html

U.S. Department of Justice, Civil Rights Division (2009). *A guide to disability rights law*. https://www.ada.gov/cguide.htm

Weissman, N., Batten, S.V., Rheem, K. D., Wiebe, S. A., Pasillas, R. M., Potts, W., Barrone, M., Brown, C. H., & Dixon, L. (2017). The effectiveness of Emotionally Focused Couples Therapy with veterans with PTSD: A pilot study. *Journal of Couple & Relationship Therapy, 17*(1), 25-41.

Wiebe, S. A., Elliott, C., Johnson, S. M., Moser, M. B., Dalgleish, T. L., Lafontaine, M-F., & Tasca, G. A. (2019). Attachment change in emotionally focused couple therapy and sexual satisfaction outcomes in a two-year follow-up study. *Journal of Couple & Relationship Therapy, 18*(1), 1-21. https://doi.org/10.1080/15332691.2018.1481799

Wiebe, S. A., Johnson, S. M., Lafontaine, M-F., Moser, M. B., Dalgleish, T. L., & Tasca, G. A. (2016). Two-year follow-up outcomes in emotionally focused couple therapy: An investigation of relationship satisfaction and attachment trajectories. *Journal of Marriage and Family Therapy, 43*(2), 227-244. https://doi.org/10.1111/jmft.12206

Wiebe, S. A., & Johnson, S. M. (2016). A review of the research in emotionally focused therapy for couples. *Family Process Institute, 55*(3), 390-406. https://doi.org/10.1111/famp.12229

Wilson, A. D., Henriksen, R. C., Jr., Bustamante, R., & Irby, B. (2015). Successful black men from absent-father homes and their resilient single mothers: A phenomenological study. *Journal of Multicultural Counseling and Development, 44,* 189-208. https://doi.org/10.1002/jmcd.12046

Wise, P. H. (2012). Emerging technologies and their impact on disability. *Future of Children, 22*(1), 169-191.

Yan, K. K., Accordino, M. P., Boutin, D. L., & Wilson, K. B. (2014). Disability and the Asian culture. *Journal of Applied Rehabilitation Counseling, 45*(2), 4-8.